

159 *Death* 10520

Reg. Dist. No. 302

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF STILLBIRTH

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street address, hospital, or institution:
25 Belleview Ave.
Length of mother's stay in County.....
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 25 Belleview Ave.
(If RURAL give LOCATION)

3. Name of child Armel
5. Sex Female | 6. Twin or triplet.....

4. Date of birth Nov. 11, 1947 Hour 9 A M.
7. No. of weeks pregnancy 6 months

FATHER OF CHILD

8. Full name Powell Page Armel
9. Color White 10. Age at time of this birth 38 yrs.
11. Usual occupation Engineer

MOTHER OF CHILD

12. Full maiden name Bellie Anna Susan Wolf
13. Color White 14. Age at time of this birth 26 yrs.
15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 2
(b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 0

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of.....

19. Labor: (a) Complications of.....
(b) Induced?.....

20. (a) Was there an operation for delivery? No
(b) State all operations, if any.....
(Yes or No)

(c) Did child die before operation?.....
During operation?.....

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes 6 months gestation

(b) Maternal causes.....

(Mother stated infant lived few min)

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature [Signature]
(Specify if M. D., midwife, or other)

Address Hagerstown, Md.

23. (a) Burial (b) Date thereof 11-12-47
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory Funkstown Md.

25. (a) Nov. 11, 1947 (b) [Signature]
(Date rec'd by registrar) (Registrar)

24. (a) Funeral director Scott F. Minnich & Son
(b) Address Hagerstown Md.

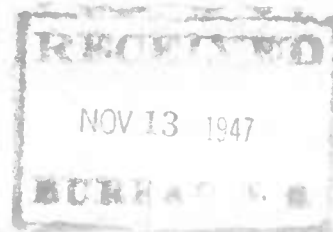
26. (To be filled out if no physician was present at delivery.)
The above certificate has been examined by me.

Health Officer, per.....

* See Instruction C on stub.

V. S. A10

Child lived few min.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

Dr. Victor Miller

10380

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Maugansville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 Years
 Hospital, institution, or street address where death occurred:
Main St.
 How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Maugansville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Main Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

WILLSON F. ARNDT

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife --
 7. Birth date of deceased (mo., day, yr.) April 6 1863
 8. AGE: Years 84 Months 6 Days 29 It less than one day -- hrs. -- min.

9. Birthplace Allentown Lehigh Co. Pa.
 (Town, county, and state)
 10. Usual occupation Broom Man ufacturer
 11. Industry or business Retired
 12. Name No Record
 13. Birthplace No Record
 14. Maiden name No Record
 15. Birthplace No Record

18. Informant J.P. Martin
 Address Maugansville Md.
 17. Burial Date thereof 11/7/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Reiffs Mennonite Cemetery
 Location Near Cearfoss Md.

19. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Nov. 6. 1947 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5 19 47 at 4:30A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 - 1947 to 11/6 19 47
 and that I last saw him alive on 11/4 19 47

Immediate cause of death chronic Endocarditis
arterio-sclerosis
Cephalitis.
 DURATION ?
 Due to arterio-sclerosis
 Due to Cephalitis.
 Other conditions --

(Include pregnancy within 3 months of death)

Major findings of operations O Date of op. --

Autopsy results O
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide -- Date of --
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) --
 Means of injury -- Injured at work? --

23. SIGNATURE Victor Miller M. D.
 Address -- Date signed 11/7 1947

RECEIVED
NOV 8 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10381302
Reg. Dist. No.

1. PLACE OF DEATH: County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>15 years</u> Hospital, institution, or street address where death occurred <u>130 Williams Avenue</u> How long in hospital or institution?		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>130 Williams Avenue</u> (If rural, give LOCATION) 2.(a) If veteran, name war	
3. (a) FULL NAME <u>Mary Josephine Arnold</u>		3. (b) Social Security Number <u>None</u>	
4. Sex <u>Female</u>		5. Color or race <u>Negro</u>	
6. (a) Single, married, widowed, or divorced <u>Married</u>		6. (b) Name of husband or wife <u>John Arnold</u>	
7. Birth date of deceased (mo., day, yr.) <u>August 10, 1908</u>		6. (c) If alive, give age years	
8. AGE: Years <u>39</u> Months <u>3</u> Days <u>5</u> If less than one day hrs. min.		20. DATE OF DEATH <u>Nov. 6</u> 19 <u>47</u> at <u>12:15 A</u>	
9. Birthplace <u>Burkittsville, Md</u> (Town, county, and state)		21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Oct 5</u> 19 <u>47</u> to <u>Nov. 6</u> 19 <u>47</u> and that I last saw h. <u>ex</u> alive on <u>Oct. 24</u> 19 <u>47</u>	
10. Usual occupation <u>Domestic</u>		Immediate cause of death <u>Squamous Carcinoma - Floor of mouth</u>	
11. Industry or business <u>William Smathers</u>		DURATION <u>8 wks?</u>	
12. Name <u>Burkittsville, Md</u>		Due to	
13. Birthplace <u>Harriet Brown</u>		Due to	
14. Maiden name <u>Burkittsville, Md</u>		Other conditions	
15. Birthplace <u>Miss Lina Butler</u>		(Include pregnancy within 3 months of death)	
16. Informant <u>130 Williams Avenue</u>		Major findings of operations <u>as above</u>	
17. Burial Date thereof <u>11/8/47</u> (Burial, cremation, or removal. Which?) (month) (day) (year)		Date of op. <u>Oct 15, 1947</u>	
Cemetery or crematory <u>Primerview Cemetery</u>		Autopsy results	
Location <u>Williamsport, Md</u>		PHYSICIAN: Please underline the cause to which death should be charged statistically.	
18. Funeral director <u>William J. Edwards</u>		22. VIOLENCE: If death was due to external causes, fill in the following:	
Address <u>291 Frederick St Maryland</u>		Accident, suicide, or homicide Date of	
19. No. 7. 47 (Date rec'd by registrar)		Where did injury occur? (City or town) (County) (State)	
Registrar		Injured at home, farm, industry, public place (where?)	
Address <u>159 W. Washington St</u>		Means of injury Injured at work?	
23. SIGNATURE <u>W. J. Edwards</u>		M. D. or other	
Address <u>Hagerstown Md</u>		Date signed <u>11/7/47</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

10382

CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH:

County Washington
City or town Park Hall - Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 mo.

Hospital, institution, or street address where death occurred:

Boonsboro Md. R. 2
How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Park Hall - Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Boonsboro Md. R. 2
(If rural, give LOCATION)2.(a) If veteran, name war No.

3. (a) FULL NAME

William Washington Beachley

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Anna May Beachley

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

February 22 - 1868

8. AGE:

Years

Months

Days

if less than one day

79814hrs.min.

9. Birthplace

Remo Fred. Co. Md.
(Town, county, and state)

10. Usual occupation

Retired Farmer

11. Industry or business

FATHER

12. Name

John Henry Beachley

13. Birthplace

Remo Fred. Co. Md.

14. Maiden name

Elizabeth Summers

15. Birthplace

Wolfville Fred. Co. Md.

16. Informant

C. E. Beachley

Address

3001 Graham Blvd. Pittsburgh 21, Penna

17.

(Burial, cremation, or removal, Which?)

Date thereof

Nov. 9, 1947
(month) (day) (year)

Cemetery or crematory

Boonsboro Cemetery

Location

Boonsboro Md.

18. Funeral director

Wm J. East & Son

Address

Boonsboro Md.

19.

(Date rec'd by registrar)

19.

47

Mr. Katherine Degenhart

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1947 at 9:15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 26 1947 to Nov 6 1947and that I last saw him alive on Nov 2 1947

Immediate cause of death

Chronic Myocarditis

DURATION

2 yrs. 3 mos

Due to

Chronic Nephritis

"

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

John Henry Beachley M.D.

M. D. or other

Address

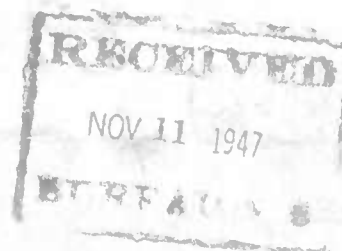
Boonsboro Md.Date signed 11/7/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10383

Reg. Dist. No. 304

1. PLACE OF DEATH:

County Washington
 City or town Hancock
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 40 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Richard Roman Bishop.

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Addie E. SmithBishop7. Birth date of deceased (mo., day, yr.) May 30, 18866. (c) If alive, give age 58 years

8. AGE:

Years

61

Months

5

Days

6

If less than one day

hrs.

min.

9. Birthplace Washington Co., Md.
(Town, county, and state)10. Usual occupation Railreader

11. Industry or business

FATHER
MOTHER

12. Name

Denton Bishop

13. Birthplace

Maryland

14. Maiden name

Ellen Haw

15. Birthplace

Maryland16. Informant Mrs. Addie Bishop

Address

Hancock, Md.

17.

Burial

(Burial, cremation, or removal, Which?)

Date thereof Nov. 9, 1947

(month) (day) (year)

Cemetery or crematory

Parkhead Evan Church Cem.

Location

U.S. Route 40 - 8 mi. East of Hancock

18. Funeral director

Charles R. Bast

Address

Hancock, Maryland

19.

11-8-47

(Date rec'd by registrar)

19.

J. G. Heller

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hancock
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

705-05-9185

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5, 1947 at 10:45 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 25, 1947 to November 5, 1947and that I last saw him alive on OCTOBER 14, 1947

Immediate cause of death

Carcinoma Pancreas
with metastasis

DURATION

?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations SAMEDate of op. SEPT. 12, 1947Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Archie Robert Cohen

M. D.

Address

Clear Spring, Md.Date signed Nov. 8, 1947

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NOV 13 1947
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

191a

10384

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WASHINGTON
City or town HAGERSTOWN
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 YRS.
Hospital, institution, or street address where death occurred:
WASHINGTON COUNTY HOSPITAL
How long in hospital or institution? 1 WEEK

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County WASHINGTON
City or town HAGERSTOWN
(If outside city or town limits, write RURAL and give nearest town)
Street No. 519 S. POTOMAC ST.
(If rural, give LOCATION)
2.(a) If veteran, name war NON - VET.

3. (a) FULL NAME

DANIEL DAVID BOWARD

3. (b) Social Security Number

215-07-4252

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 6, 1872

8. AGE: Years 75 Months 4 Days 29 It less than one day hrs. min.

9. Birthplace FALLING WATERS, BERKLEY, W. VA.
(Town, county, and state)

10. Usual occupation SILK WEAVER

11. Industry or business SILK MILL

12. Name DENTON BOWARD

13. Birthplace HAGERSTOWN, MD.

14. Maiden name LAURA RIDENOUR

15. Birthplace HAGERSTOWN, MD.

16. Informant Raphael Boward (nephew)

Address 321 S. Cannon ave

17. Burial Date thereof 11/7/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill

Location Hagerstown Md.

18. Funeral director Woodford J. Hornum

Address Hagerstown Md.

19. Nov. 6, 47 Chas. H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/5 1947 at 10/1 47 to 11/5 47

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/1 47 to 11/5 47 and that I last saw him alive on 11/5 47

Immediate cause of death Chronic Nephritic Heart
arterio-sclerosis

DURATION

Due to arterio-sclerosis
Due to
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

SIGNATURE Wm. S. Miller M. D. or other

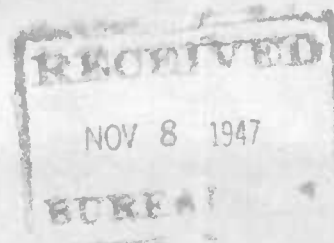
Address Hagerstown Md. Date signed 11/6 1947

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10385

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
City or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred:
328 W. Howard Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington
City or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 328 West Howard Street
(If rural, give LOCATION)
2(a) If veteran, name war.

3. (a) FULL NAME

William H. Bowers

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Lousia K. Bowers
6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) October 8, 1872
8. AGE: Years 75 Months 1 Days 19 It less than one day hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1947 at 5:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6 1946 to Nov. 27 1947 and that I last saw him alive on Nov. 14 1947
Immediate cause of death Hypertensive Heart Disease 18 mos.
Due to
Due to
Other conditions Pulmonary embolism 18 mos.
(Include pregnancy within 8 months of death)

9. Birthplace Penna. (Town, county, and state)
10. Usual occupation Retired Tinner
11. Industry or business
12. Name Unknown
13. Birthplace Unknown
14. Maiden name
15. Birthplace

Major findings of operations... Date of op.
Autopsy results...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

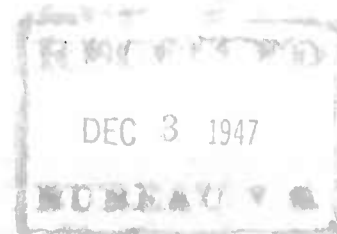
16. Informant Mrs. Lousia K. Bowers
Address 328 W. Howard St. Hagerstown, Md.
17. Burial Date thereof Dec. 1, 1947 (Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown, Maryland
18. Funeral director Fred W. Kraiss
Address Hagerstown, Maryland.
19. Dec. 1, 1947 (Date rec'd by registrar) Registrar

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... Date of...
Where did injury occur? City or town County State
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Philip J. Williams M.D. or other
Address 159 W. Washington St. Date signed 11/28/47

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10389

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington County
City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 10-9-47 to 11-3-47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1029 Concord St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

WILLIAM DAVID DAUGHERTY

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Emma Schuyler Daugherty

7. Birth date of deceased (mo., day, yr.) March 18 1862 6. (c) If alive, give age 66 years

8. AGE: Years 85 Months 7 Days 15 It less than one day hrs. min.

9. Birthplace Adams County Pa.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name David Daugherty
13. Birthplace Adams Co. Pa.

14. Maiden name Eliza J. Herbst
15. Birthplace Adams Co. Pa.

16. Informant Alvah L. Stonesifer
Address Cartanna Pa.

17. Burial Nov. 6, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Union Cemetery

Location Fairfield, Pa.

18. Funeral director H. L. Allison
Address Fairfield, Pa.

19. Nov. 6 1947
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2, 1947 at 6:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1947 to November 2, 1947 and that I last saw him alive on Oct 31, 1947

Immediate cause of death Abdominal incision DURATION 1 week
Due to Malnutrition 4.5 mo

Due to Old duodenal ulcer with obstruction 4 mo
Other conditions Chronic Pancreatitis

(Include pregnancy within 3 months of death)

Major findings of operations Duodenal ulcer with obstruction due to adhesions Date of op. 15 Oct 47
Autopsy results Not performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Layman M.D.
Address 1009 Jefferson St. Hagerstown Md. Date signed Nov 1947

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 8 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

872

10386

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 years
 Hospital, institution, or street address where death occurred:
14 Randolph Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 14 Randolph Avenue
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Eliza Jacques Brenner

3. (b) Social Security Number

NONE

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced
 6. (b) Name of husband or wife
 6. (c) If alive, give age, years
 7. Birth date of deceased (mo., day, yr.) April 17, 1892
 8. AGE: Years 55 Months 6 Days 22 If less than one day, hrs. min.

9. Birthplace Clearspring, Maryland
(Town, county, and state)10. Usual occupation Retired Stenographer

11. Industry or business

MOTHER FATHER
 12. Name Samuel G. Jacques
 13. Birthplace Indian Spring, Maryland
 14. Maiden name Sally M. Kreps
 15. Birthplace Clearspring, Maryland

16. Informant Mrs. S. G. Jacques
 Address Hagerstown, Maryland

17. Burial Date thereof 11-10-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Smithsburg CemeteryLocation Smithsburg, Maryland18. Funeral director C. M. Suter & SonsAddress Hagerstown, Maryland

19. No. 8. 47 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

11/8 1947 at 7 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to 11/8 1947 and that I last saw him alive on 11/7 1947

Immediate cause of death Multiple Sclerosis 6-7 years
Chronic Sudo Carditis
 Due to (valvular)

Due to

Other conditions 0

(Include pregnancy within 3 months of death)

Major findings of operations 0Autopsy results 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following.

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE V. D. Miller M. D.

DR. VICTOR D. MILLER.

Address 131 W. WASHINGTON, ST. Date signed 11/8-1947

THIS FORM IS TO BE FILLED OUT BY THE OFFICIAL IN CHARGE OF THE DEATH RECORD. IT IS TO BE FILED IN THE DEATH RECORD OF THE COUNTY WHERE THE DEATH OCCURRED. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO ANY PERSON WHO REQUESTS IT. IT IS TO BE MADE AVAILABLE TO ANY PERSON WHO REQUESTS IT.

MARYLAND STATE DEPARTMENT OF HEALTH
2111 M. Charles St., Baltimore
CERTIFICATE OF DEATH

1. USUAL RES. (For name)

2111

City or town

2111

1. PLACE OF DEATH:

County

City or town

2. How long in place; last 24 hours

How long in place; last 24 hours

How long in place; last 24 hours

How long in place; last 24 hours

2. (a) FULL NAME

3. (a) Date of death

3. (b) Time of death

3. (c) Cause of death

3. (d) Place of death

3. (e) Place of death

3. (f) Place of death

3. (g) Place of death

3. (h) Place of death

3. (i) Place of death

3. (j) Place of death

3. (k) Place of death

3. (l) Place of death

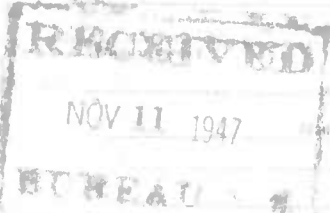
3. (m) Place of death

3. (n) Place of death

3. (o) Place of death

3. (p) Place of death

3. (q) Place of death



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157a

Dr. Linson

10387

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 months
 Hospital, institution, or street address where death occurred:
Washington county Hospital
 How long in hospital or institution? 6 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 277 So. Potomac St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

LESTER DOUGLAS BREWER

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife --
 7. Birth date of deceased (mo., day, yr.) May 14 1947
 8. AGE: Years Months Days If less than one day
5 21 hrs. min.

9. Birthplace Hagerstown Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Infant
 11. Industry or business --

12. Name William E. Brewer
 13. Birthplace Brooklyn New York
 14. Maiden name Helen Barkdoll
 15. Birthplace Hagerstown Md.

16. Informant William E. Brewer
 Address Hagerstown Md.

17. Burial Date thereof 11/7/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Nov. 7, 47 Lester H. Brewer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5 1947 19 47 at 8:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 14 19 47, to Nov. 6 19 47
 and that I last saw him alive on Nov 5 19 47

Immediate cause of death Respiratory failure
 DURATION

Due to Hydrocephalus

Due to

Other conditions Meningocele

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Hydrocephalus + meningocele
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Elizabeth L. Linson M. D.

Address 214 N. Potomac St. Date signed 11-6-47

RECEIVED

NOV 16 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

836

10388

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:

County... Washington
 City or town... Near Leavittown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 1/2 yrs.
 Hospital, institution, or street address where death occurred: —
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington
 City or town... Near Leavittown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. none
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME

Joseph. Ardy. Brown.

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widowed

6. (b) Name of husband or wife not living7. Birth date of deceased (mo., day, yr.) 3-1-1864 8. (c) If alive, give age not living

8. AGE:	Years	Months	Days	It less than one day
	83	2	29	— hrs. — min.

9. Birthplace Near Foxville Fred Co md
(Town, county, and state)

10. Usual occupation

Farmer.

11. Industry or business

12. Name George F. Brown13. Birthplace Near Foxville Fred Co md14. Maiden name May Buzzard15. Birthplace Near Foxville Fred Co md16. Informant Frank K. BrownAddress Leavittown md17. Burial Date thereof 11-4-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory SmithsburgLocation Smithsburg Md18. Funeral director Geo W HooverAddress Smithsburg md19. Nov 3 1947 Geo W Ferguson
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2 1947 at 4A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 2 1947 to Nov 2 1947 and that I last saw him alive on Nov 2 1947Immediate cause of death Heart of 7 months is DURATION 10 mts.Due to Intest 5 cm size 10 ydsDue to —Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE G. G. K. Ober M. D. or otherAddress Smithsburg md Date signed 11/3/47

RECEIVED
NOV 5 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:
 County... Washington
 City or town... Williamsport
 (If outside city or town limits, write RURAL and give nearest town)
5 Hours
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Western Md. R.R. line Byron's Tannery
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town... Halfway
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2113 Gay Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war... World War II

3. (a) FULL NAME
Bernard Glen Davis

3. (b) Social Security Number
217-09-9500

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Nellie Mae Davis
 7. Birth date of deceased (mo., day, yr.) May 14, 1919 6. (c) If alive, give age 27 years
 8. AGE: Years 28 Months 6 Days 7 If less than one day
 ...hrs. ...min.

9. Birthplace Fairplay, Washington, Maryland
 (Town, county, and state)

10. Usual occupation Conductor & extra brakeman

11. Industry or business Western Md. Railroad

FATHER 12. Name Harry Raymond Davis
 13. Birthplace Williamsport, Md. RFD#1

MOTHER 14. Maiden name Mary K. Miller
 15. Birthplace Fairplay, Maryland

16. Informant Mary K. (Miller) Davis
 Address Fairplay, Maryland

17. Burial Date thereof Nov. 23, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Greenlawn Cemetery
Williamsport, Maryland
 Location

18. Funeral director Mrs. Edith V. Leaf
 Address Williamsport, Maryland.

19. Nov 24 19 47 Mrs. E. Lee McElroy
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Nov 21/47 19 11:45A M

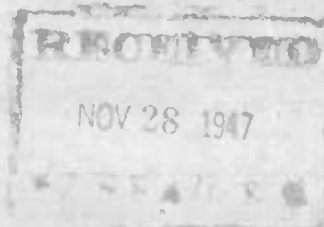
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 ...19... to ...19...
 and that I last saw him... alive on ...19...

Immediate cause of death...
crushed abdomen
 Due to... crushed vertebral column
 Due to...
 Other conditions...
 (Include pregnancy within 3 months of death)

Major findings of operations... Date of op...
 Autopsy results... no
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide accident Date of 11/21/47
 Where did injury occur? Williamsport, Wash. Md.
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) at work West. Md. RR tra
 Means of injury caught between injured at work? RR cars

23. SIGNATURE S. Robert Wells WASH. CO., MD.
 Address... Hagerstown, Md. DEPUTY MEDICAL EXAMINER
 M. D. or other
 Date signed... Nov 21/47
 WASH. CO., MD.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Welty

10391

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown R # 6
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 Years
 Hospital, institution, or street address where death occurred:
Leitersburg Pike
 How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown R # 6
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Leitersburg Pike
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

MRS. MARY ANN DEIBERT

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife Charles H.
 7. Birth date of deceased (mo., day, yr.) June 11 1866
 8. AGE: Years 81 Months 4 Days 26 If less than one day hrs. min.
 8.(c) If alive, give age -- years

9. Birthplace St. James Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home
 12. Name Isaac Rowland
 13. Birthplace St. James Md.
 14. Maiden name Ellen Mongan
 15. Birthplace St. James Md.

16. Informant Mrs. Charlotte White
 Address Hagerstown Md. R # 6
 17. Burial Date thereof 11/9/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown Md.
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Nov. 8. 47 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

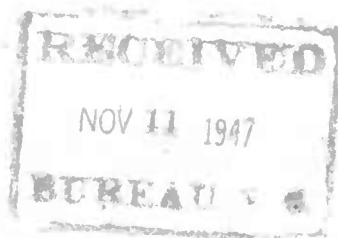
20. DATE OF DEATH November 7 47 at 4.30 M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 47, to November 7 19 47
 and that I last saw him alive on Nov. 6 19 47
 Immediate cause of death Coronary - Arteriosclerosis
Heart Disease
 DURATION 4 yrs.
 Due to Ischemic Myocarditis
 Other conditions 6 yrs
 (Include pregnancy within 3 months of death)

Major findings of operations Ischemic Myocarditis
 Date of op. 6 yrs

Autopsy results Ischemic Myocarditis
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Ischemic Myocarditis Date of 11-7-47
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Manner of injury Injured at work?

23. SIGNATURE Saltzman M. Welty M.D.
 Address 998 P Street N.W. Hagerstown Date signed 11-7-47



Evidence for the change of
given name is shown on
114 1/7/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

10392

302

1. PLACE OF DEATH: Washington
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Fulton
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME EMORY D.
Henry D. Diehl Sr.

3.(b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Irene D. Diehl
6.(c) If alive, give age 69 years
7. Birth date of deceased (mo., day, yr.) August 12, 1879

8. AGE: Years 68 Months 3 Days 7
If less than one day hrs. min.

9. Birthplace Fulton Co. Pa.
(Town, county, and estate)
Retired

10. Usual occupation None
11. Industry or business

12. Name Samuel Diehl
13. Birthplace Fulton Co. Pa.
14. Maiden name Fannie Heff
15. Birthplace Fulton Co. Pa.

16. Informant Mrs. Irene Diehl
Address McConnellsburg Pa.

17. Burial Date thereof 11-22-47
(Burial, cremation, or removal. Which) (month) (day) (year)
Cemetery or crematory Union Cemetery
Location Fulton Co. Pa.

18. Funeral director Scott F. Minnich & Son
Address Hagerstown Md.

19. Nov. 20, 47
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 47 at 4:20p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov. 11 1947 to Nov 19 1947
and that I last saw him alive on Nov. 19 1947

Immediate cause of death
UREMIA. ACUTE -
Cause undetermined (10/47 dec)
Due to Cerebral atherosclerosis
p. sclerosis

Due to
Other conditions

(Include pregnancy within 3 months of death)
Major findings of operations None.

Antopsy results Same.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Archie Robert Cohen
Address Clear Spring Md Date signed 11-20-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The copy is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Wm Layman

10393

Reg. Dist. No. 3057

1. PLACE OF DEATH:

County Washington
 City or town Boonsboro
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 19 Days
 Hospital, institution, or street address where death occurred:
Guilford Convalescent Home
 How long in hospital or institution? 19 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Boonsboro R # 1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. State Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

MRS. ANNA HAMBURG DINSMORE

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife Wm. A. Dinsmore
 7. Birth date of deceased (mo., day, yr.) March 23 1873
 8. AGE: Years 74 Months 7 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Hagerstown Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Abram Hamburg

13. Birthplace Cascade Md.

14. Maiden name Evaline Cover

15. Birthplace Thurmont Md.

16. Informant W. Earl Dinsmore

Address Hagerstown Md.

17. Burial Date thereof 11/25/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Nov. 24. 19 47 John H. Carl
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH November 22 1947 19 47 at 1 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 983 19 47 to Nov 22 19 47
 and that I last saw him alive on Nov 18 19 47

Immediate cause of death Myocardial infarction -
vascular disease

DURATION

?

Due to _____

Due to _____

Other conditions Chronic Pulmonary Tuberculosis ?
Tuberculosis peritonitis 2 1/2 hrs
 (Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. J. Layman M.D.
W. J. Layman M.D. M. D. or other _____
 Address Hagerstown Md. Date signed 24 Nov 1947

RECEIVED

NOV 28 1947

BUREAU V C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

Dr. Wells

10394

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 16 Years
 Hospital, institution, or street address where death occurred:
900 Concord St.
 How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 900 Concord St.
 (If rural, give LOCATION)
 2(a) If veteran, name war None

3. (a) FULL NAME

GEORGE DOMINICK

3. (b) Social Security Number

705-10-6237

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower

6. (b) Name of husband or wife Maria
 6. (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) August 13, 1877

8. AGE: Years 70 Months 3 Days 16 If less than one day hrs. min.

9. Birthplace San Luca, Italy
 (Town, county, and state)

10. Usual occupation Trackman

11. Industry or business Western Maryland Rail Road

12. Name Bastario Dominick
 13. Birthplace Italy

14. Maiden name Mary Tereso
 15. Birthplace Italy

16. Informant Elgio Melvin Cordelli
 Address Hagerstown Md.

17. Burial 12/2/47
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Dec. 1, 47
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29, 1947 at 8:30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death Chronic myocarditis DURATION 2 yrs.

Acute ventricular fibrillation.
 Due to ation.

Due to ation.

Other conditions ation.

(Include pregnancy within 3 months of death)

Major findings of operations ation.

Date of op. ation.

Autopsy results ation.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of ation.

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ation.

Means of injury ation. Injured at work? ation.

23. SIGNATURE S. Robert Wells DEPUTY MEDICAL EXAM.

Hagerstown, Md. WASH. CO., MD.

M. D. or other Nov. 29, 47

Address Hagerstown, Md. Date signed Nov. 29, 47

RECEIVED
DEC 3 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Inform exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

10395

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
 City or town Rural :- MAPLEVILLE
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Auto accident
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State W. Va. County Bereky
 City or town Martinsburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 516 Buxton St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war World War LI

3. (a) FULL NAME

Kenneth Ward Dyche

3. (b) Social Security Number

232-26-6380

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Lyda Jane Kitchen Dyche6. (c) If alive, give age 25 years7. Birth date of deceased (mo., day, yr.) August 16, 1922

8. AGE: Years 25 Months 3 Days - If less than one day hrs. min.

9. Birthplace Martinsburg, Bereky Co., W. Va.
(Town, county, and state)10. Usual occupation Plant operator11. Industry or business Dairy12. Name Earl B. Dyche13. Birthplace Bereky Springs, W. Va.14. Maiden name Lara Elva Ward15. Birthplace Mineral Co., W. Va.16. Informant Lyda J. K. DycheAddress Martinsburg, W. Va.17. Burial Date thereof 11-18-47
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Rosedale CemeteryLocation Martinsburg, W. Va.18. Funeral director Scott F. Minnich & SonAddress Hagerstown, Md.19. Nov. 16, 47 John D. Bart
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1947 at 1:20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Fractured skullDue to Crushed chestDue to (Suffocation) and shock

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results No-(spinal fluid for alcohol)

PHYSICIAN: Please order the case to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Nov. 16/47Where did injury occur? Mapleville Wash. Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Route #66Means of injury Fell out of car & auto fell on bodyDEPUTY MEDICAL EXAMINER WASH. CO., MD.23. SIGNATURE S. Robert Wells M. D. or other Nov. 16/47Address Hagerstown, Md. Date signed Nov. 16/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

10396

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 229 Fredrick St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary K. Fahrney

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Clayton Fahrney

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 18658. AGE: Years 82 Months 9 Days 27 If less than one day
hrs. min.9. Birthplace Franklin Co., Penna.
(Town, county, and state)10. Usual occupation Home duties

11. Industry or business

12. Name Henry Cleverstone13. Birthplace Greencastle, Pa.14. Maiden name Catherine Starny15. Birthplace Waynesboro, Pa.16. Informant Mrs. J. A. ForsytheAddress 147 E. Baltimore St. Hagerstown, Md.17. Burial Date thereof Nov. 13, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Md.18. Funeral director Fred W. KraissAddress Hagerstown, Md.19. Nov. 13, 47 Charles Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10, 1947, at 3:15 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 1942, to November 10, 1947and that I last saw her alive on November 10, 1947Immediate cause of death Bronch-pneumonia DURATION 4 days

Due to

Due to

Other conditions Chronic Myocarditis 5 years

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results no autopsy Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. Schaefer M. D. or otherAddress 148 W. Washington Street Date signed Nov 13, 1947

RECEIVED

NOV 15 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

10397

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Life
 Hospital, institution, or street address where death occurred:
232½ North Potomac Street
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 232½ North Potomac Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

Mary Kate Fechtig

3. (b) Social Security Number

NONE

4. Sex..... Female 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Widow
 6. (b) Name of husband or wife..... Charles C. Fechtig
 7. Birth date of deceased (mo., day, yr.)..... August 14, 1852
 8. AGE: Years..... 95 Months..... 3 Days..... 1 (If less than one day, hrs. min.)

9. Birthplace..... Hagerstown, Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation..... Housework

11. Industry or business..... Own Home

12. Name..... Joseph Smith

13. Birthplace..... Greencastle, Pa.

14. Maiden name..... Elizabeth Bragunier

15. Birthplace..... Washington County, Md.

16. Informant..... Mrs. Naomi Hearon

Address..... Hagerstown, Maryland

17. Burial..... 11-18-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Paul Cemetery

Location..... Western Pike,

18. Funeral director..... C. M. Suter & Sons

Address..... Hagerstown, Maryland

19. Nov. 18, 1947
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov/15/47 19..... 7:20P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19. 34 to..... Sept/18

and that I last saw her..... alive on..... Sept/20 19..... 47

Immediate cause of death.....

..... Chr. myocarditis DURATION..... 5 yrs

Due to..... acute ventricular fibrillation

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... no Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... A. Robert Thell, M.D. M. D. Nov. 17/47

Address..... Hagerstown, Md. Date signed.....

THE UNIVERSITY OF CHICAGO

23

ព្រះបាទ នរោត្តម ៩

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Industry or business:

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Author's address: *University of Bremen, School of Business Administration, Postbox 330440, 28334 Bremen, Germany. E-mail: christian.buchner@uni-bremen.de*

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

...the most important of which is...

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BUREAU 7-10

NOV 20 1947

RECORD

PLACE OF DEATH:

no. 411281 to 411283, 3 vol.

3 MAY 2014

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Intend to pass a good bill and will

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U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

CERTIFICATE OF DEATH

9441 N. Charles St., Baltimore

DEPARTMENT OF STATE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. **Correct age** is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10398

Reg. Dist. No.

304

1. PLACE OF DEATH:
 County..... Washington
 City or town..... Rural Hancock, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 years
 Hospital, institution, or street address where death occurred:
Hancock, Md. R D 1
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Rural Hancock, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hancock, Md. R D 1
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
Nancy Ellen Fisher

3. (b) Social Security Number
None

4. Sex..... Female 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Widow
 6. (b) Name of husband or wife..... Calendine Fisher
 7. Birth date of deceased (mo., day, yr.)..... April 4, 1864 B. (c) If alive, give age..... years
 8. AGE: Years..... 83 Months..... 7 Days..... 0 If less than one day..... hrs. min.

9. Birthplace..... Fulton County, Pa.
 (Town, county, and state)
 10. Usual occupation..... Home Duties
 11. Industry or business.....
 12. Name..... Joseph Barnhart
 13. Birthplace..... Fulton County, Pa.
 14. Maiden name..... Mary
 15. Birthplace..... Fulton County, Pa.

16. Informant..... Archie Fisher
 Address..... Hancock, Md. R D 1
 17. Burial Date thereof..... Nov. 6, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Cedar Grove Cemetery
 Location..... Near Dott, Pa.
 18. Funeral director..... Snyder-Rowland Funeral Home
 Address..... Hancock, Md.
 19. 11/5/47 19..... J. H. Fisher
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... November 4, 1947 12:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov 4 1947 to Nov 4 1947
 and that I last saw him/her alive on Nov 4 1947

Immediate cause of death.....
Chronic Myocarditis
arterio sclerosis
 Due to.....
 Due to.....
 Other conditions.....

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE..... J. H. Fisher M. D. or other
 Address..... Hancock, Md. Date signed..... 11/5/47

RECEIVED

NOV 8 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr/Corad

Reg. Dist. No. 103805

1. PLACE OF DEATH:

County Washington
 City or town Breathedsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 months
 Hospital, institution, or street address where death occurred:
Md. State Reformatory for Males
 How long in hospital or institution? 3 Mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1108 W. Lexington St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

FREDERICK I. FOSTER

3. (b) Social Security Number

None 217-16-6597

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Colored Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October 20 19248. AGE: Years Months Days If less than one day
23 0 20 hrs. min.9. Birthplace Baltimore Md.
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name No. record13. Birthplace No Record14. Maiden name Chaney Foster15. Birthplace Baltimore16. Informant Records of Md. State Ref. for MalesAddress Breathedsville Md.17. Burial Date thereof 11/13/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mount Auburn CemeteryLocation Baltimore, Maryland18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Nov. 12 19 47 John H. Best
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 19 47 at 4:30 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 27 19 47 to Nov 10 19 47and that I last saw him alive on Nov 9, 1947Immediate cause of death Pulmonary TuberculosisDURATION 1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

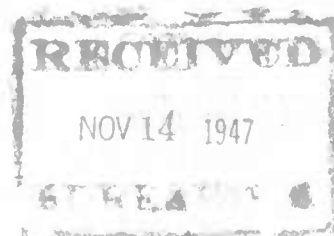
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert P. Conrad, M.D. M. D. or otherAddress Hagerstown, Md Date signed 11-10-47



68
12
MARGIN RESERVED FOR BINDING
VS A15
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

50 X
BC 10400 306
Reg. Dist. No. 744

1. PLACE OF DEATH:

County WashingtonCity or town Cascade
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 daysHospital, institution, or street address where death occurred: Pitche HospitalHow long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore CityCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1403 Cascade St.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME

Agnes George

3. (b) Social Security Number

4. Sex Female5. Color of race White6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Rudolph7. Birth date of deceased (mo., day, yr.) Jan. 21, 19068. AGE: Years 41 Months 9 Days 21 It less than one day hrs. min.9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name August Yaworski13. Birthplace Poland14. Maiden name Mary Frish15. Birthplace Poland16. Informant Pitche HospitalAddress Cascade, Md.17. Burial Date thereof Nov. 15, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Mary'sLocation Agnes Quindel Co. Md.18. Funeral director M. L. Cramer & Son & Co.Address Thurmont, Md.19. Nov. 12 19 47 Blanche J. Eyer
(Date rec'd by registrar) RegistrarNov 12 47 Geo. W. Ferguson

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 19 47 at 11 40 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 7 19 47 to November 12 19 47 and that I last saw him alive on November 12 19 47Immediate cause of death Carcinomatosis DURATION 5 monthsDue to Carcinoma of Breast 1 year?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Breast
Johns Hopkins Hosp. Date of op. Dec. 13, 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

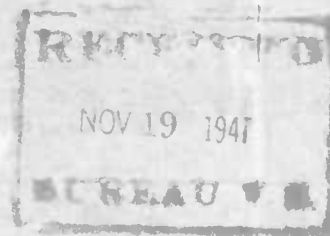
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Injured at work?

Signature Thomas M. Orrington M.D.Address Pitche Hospital Date signed Nov 12 1947
Cascade, Md.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

950

10401

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
City or town Appleton Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 60 yearsHospital, institution, or street address where death occurred
Boonsboro Md. Route 2How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Appleton - Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Boonsboro Md. R. 2
(If rural, give LOCATION)2.(a) If veteran, name war no.

3. (a) FULL NAME

Lottie May Green

3. (b) Social Security Number

None.

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

Single.

7. Birth date of

deceased (mo., day, yr.)

September - 4 - 1880

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

6721

hrs.

min.

8. Birthplace near Boonsboro Wash. Co. Md.
(Town, county, and state)

10. Usual occupation

Housekeeper

11. Industry or business

Own home

FATHER

12. Name

Daniel P. Green

13. Birthplace

near Boonsboro Wash. Co. Md.

MOTHER

14. Maiden name

May a. Marker

15. Birthplace

near Myersville Ind. Co. Md.

16. Informant

Carmela W. Green

Address

Boonsboro Md. R. 2

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

Nov 8 - 1947
(month) (day) (year)

Cemetery or crematory

Boonsboro Cemetery

Location

Boonsboro Md.

18. Funeral director

Address

Wm J. Best & Sons
Boonsboro Md.

19.

(Date rec'd by registrar)

Nov. 8 - 19471947John H. Best

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 - 1947 at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 7 - 1947 to Nov 5 - 1947and that I last saw him alive on Nov 5 - 1947

Immediate cause of death

Coronary Thrombosis

DURATION

2 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John H. BestM. D.

M. D. or other

Address

Boonsboro Md.Date signed 11/7/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 11 1947
STRA

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10402 302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 years
 Hospital, institution, or street address where death occurred:
Garlock Conv. Home
 How long in hospital or institution? 9 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1310 Oak Hill Avenue
 (If rural, give LOCATION)
 2. (a) If veteran, name war...

3. (a) FULL NAME

Jessie C. Harris

3. (b) Social Security Number

NONE

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Walter Harris
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) June 7, 1861
 8. AGE: Years 86 Months 5 Days 17 If less than one day _____ hrs. _____ min.
 9. Birthplace River Fall, Wisconsin
 (Town, county, and state)
 10. Usual occupation Retired
 11. Industry or business

12. Name George Mappes
 13. Birthplace Not Known
 14. Maiden name Ellen Gates
 15. Birthplace Not Known
 16. Informant Mrs. E. D. Plummer
 Address Hagerstown, Maryland

17. Burial Date thereof 11-27-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Waverly Cemetery
 Location Waverly, Virginia
 18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland
 19. Nov. 25 47 BlackBower
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Nov 19 47 at 530 P M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 35 to 24 Nov 19 47
 and that I last saw her alive on 23 Nov 19 47
 Immediate cause of death arterio-sclerotic Cardio Vascular
disorder DURATION 15-20 yrs
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations None Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE J J Husby M. D. or other
2301 P Plummer Address _____ Date signed 25 Nov 47

RECEIVED

NOV 28 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Ditto

10403

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1823 Virginia Ave.How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 1823 Virginia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

None

3. (a) FULL NAME

MRS NELL BOWMAN HARTZELL

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Rev. Walter Hartzell6.(c) If alive, give age 65 years

7. Birth date of

deceased (mo., day, yr.)

October 26, 1894 1894

8. AGE:

Years

Months

Days

If less than one day

53015hrs.min.9. Birthplace Harrisonburg, Rockingham Co., Va.
(Town, county, and state)

10. Usual occupation

Matron

11. Industry or business

Homewood Church Home

12. Name

John R. Bowman

13. Birthplace

Harrisonburg Va.

14. Maiden name

Ocieola Michael

15. Birthplace

Harrisonburg Va.

16. Informant

Rev. Walter R. Hartzell

Address

Hagerstown Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 11/15/47

(month) (day) (year)

Cemetery or crematory

St. Andrews Union Cemetery

Location

Perkasie Pa.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

19.

Nov. 14, 1947
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 19 47 ad 2 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 19 46, to Nov 11 - 47
and that I last saw him alive on Nov 10 - 47 19

Immediate cause of death

DURATION

Carcinoma Cervix2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

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NOV 17 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10404

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1 Week
 How long in hospital or institution? Washington County Hospital

3. (a) FULL NAME

Denia Morgan Henderson

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

July 8, 1947

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

47

hrs.

min.

9. Birthplace

Hagerstown, Wash.; Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

Joseph Henderson

13. Birthplace

Williamsport, Md

14. Maiden name

Helma Henderson

15. Birthplace

Burkittsville, Md

16. Informant

Mrs. Joseph Henderson

Address

138 Williams Ave.17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

11/18/47
(month) (day) (year)

Cemetery or crematory

Winneville Cemetery

Location

Williamsport, Md

18. Funeral director

Wm H Downey

Address

291 Frederick St.19. Nov. 18, 1947

(Date rec'd by registrar)

19. 47Geoff Bowers

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 138 Williams Ave

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 19 47 at 7:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 10 19 47 to Nov. 15 19 47and that I last saw him alive on Nov. 15 19 47

Immediate cause of death

Whooping Cough

DURATION

3 wks.

Due to

Due to

Other conditions

Pneumonia
Acute

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Chris Williams

M. D. or other

Address

Hagerstown Md

Date signed

4/17/67

RECEIVED
NOV 20 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

191a

10405

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
428 W. Franklin St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 428 W. Franklin St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3.(a) FULL NAME

Sarah Annie Henson

3.(b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

John Henson

6.(c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

January 16, 1879

8. AGE:

Years
68Months
9Days
16

If less than one day

hrs. min.

9. Birthplace

Hagerstown, Wash. Co. Md.
(Town, county, and state)

10. Usual occupation

Home Duties

11. Industry or business

FATHER
MOTHER

12. Name

John Henson

13. Birthplace

Hagerstown, Md.

14. Maiden name

Sarah Ann Slaughter

15. Birthplace

Hagerstown, Md.

16. Informant

Mrs. Mary A. Maddran

Address

Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?)

BurialDate thereof Nov. 4, 1947
(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown, Md.

18. Funeral director

Fred W. Kraiss

Address

Hagerstown, Md.

19. (Date rec'd by registrar)

Nov. 4, 1947

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Nov 1 19 47 at 2:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 1 19 45 to Nov 1 19 47and that I last saw him alive on Nov 1 19 47

Immediate cause of death

Chr. Myocarditis
Chr. tuberculous nephritis

DURATION

5 yrs.
5 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Robert P. Conrad, M.D.

M. D. or other

Address Hagerstown, Md. Date signed Nov 3, 1947

MARGIN RESERVED FOR STAMPING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 6 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

10406

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County WASHINGTONCity or town HAGERSTOWN
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 WEEKS

Hospital, institution, or street address where death occurred:

WASHINGTON COUNTY HOSPITALHow long in hospital or institution? 3 WEEKS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County WASHINGTONCity or town CEARFOSS, HAGERSTOWN RT. #1
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2. (a) If veteran, name war NON-VET.

3. (a) FULL NAME

LIZZIE M. HORST

3. (b) Social Security Number

NONE

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED8. (b) Name of husband or wife MARTIN M. HORST

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

JULY 23, 1879

8. AGE:

68

Years

4

Months

Days

1

If less than one day

hrs.

min.9. Birthplace LEITERSBURG, WASHINGTON, MD.
(Town, county, and state)10. Usual occupation HOUSEWIFE

11. Industry or business

MOTHER FATHER

12. Name

JOHN A. STRITE

13. Birthplace

MARYLAND

14. Maiden name

KATHERINE MAUN

15. Birthplace

PENNSYLVANIA

16. Informant

Mrs. Mervin Martin

Address

Hanover, Pa.

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

11/27/47

(month) (day) (year)

Cemetery or crematory

Ruff Cemetery

Location

Washington County, Md.

18. Funeral director

Goodford J. Flanagan

Address

Hagerstown, Md.

19. (Date rec'd by registrar)

Nov. 24, 47

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 - 47 at 9 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 1 - 47 to Nov 24 - 47and that I last saw Nov 24 - 47 alive on Nov 24 - 47

Immediate cause of death _____

DURATION

Cancer Vascular Disease 6 yrs

Due to _____

Due to Encephalitis 10 yrs

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. A. Strite

M. D. or other _____

Address Hagerstown, Md.Date signed Nov 24, 47

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NOV 26 1947
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 66 years
Hospital, institution, or street address where death occurred:
Washington County Home
How long in hospital or institution? 15 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Harry Lehman Jones

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Eva Jones
6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) December 15, 1880

8. AGE: Years 66 Months 11 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace Hagerstown, Wash. Co., Md.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

FATHER 12. Name Samuel Jones
13. Birthplace Hagerstown, Md.

MOTHER 14. Maiden name Raechel Smith
15. Birthplace Hagerstown, Md.

16. Informant Mrs. Wm. E. Seaman
Address McKeesport, Penna.

17. burial Date thereof 11-28-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery
Hagerstown, Md.
Location

18. Funeral director Scott F. Minnich & Son
Address Hagerstown, Md.

19. Nov. 27, 47 Shackelton
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25, 1947 at 3:10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 12th 1947 to Nov. 25 1947
and that I last saw him alive on Nov. 19th 1947

Immediate cause of death Arteriosclerosis DURATION 2 yrs.

Due to Thrombo-phlebitis right leg 4 wks.

Due to Gangrene right heel 3 wks.

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Mans of Injury _____ Injured at work? _____

23. SIGNATURE Ernest F. Pohlman M. D. or other _____

Address Hagerstown, Md. Date signed 11/26/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 29 1947

DEPT OF STATE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10408 302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 434 George Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Jo Richard Jones

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

April 9, 1943

8. AGE:

Years

Months

Days

If less than one day

4

7

17

hrs.

min.

9. Birthplace

Hagerstown, Wash. Co. Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

George W. Jones

13. Birthplace

Hagerstown, Maryland

MOTHER

14. Maiden name

Francis Elizabeth Davis

15. Birthplace

Highfield, Maryland

16. Informant

Mr. George W. Jones

Address

434 George St. Hagerstown, Md

17.

(Burial, cremation, or removal, Which?)

Date thereof

Nov. 29, 1947

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown, Maryland

18. Funeral director

Fred W. Kraiss

Address

Hagerstown, Maryland.

19.

Dec. 1, 1947

19

E. H. Bowerat

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Nov 19 47 at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

24 Nov19 47to 26 Nov19 47

and that I last saw him alive on

25 Nov19 47

Immediate cause of death

Tetanus.

DURATION

36 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. H. Bowerat

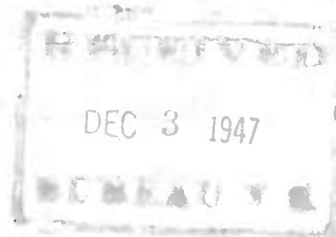
M. D. or other

Address

115 W W Adams St

Date signed

11/28/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10409

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs
 Hospital, institution, or street address where death occurred:
250 Frederick St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wash
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 250 Frederick St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Susan Jones

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Edward F. Jones
 7. Birth date of deceased (mo., day, yr.) 1880 6.(c) If alive, give age _____ years
 8. AGE: Years 67 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business
 12. Name Thomas Clipp
 13. Birthplace Maryland
 14. Maiden name Elizabeth Hoffmaster
 15. Birthplace Maryland

16. Informant Lloyd W. Jones
 Address Knoxville, Md.
 17. Burial Date thereof _____
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Brethern
Brownsville, Md.
 Location

18. Funeral director C. H. Feeler & Pro.
 Address Brunswick Md.
 19. Nov. 7. 19 47 Elizabeth Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 19 47 at 9:40 A
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____
 and that I last saw him _____ alive on _____ 19 _____
 Immediate cause of death Acute cerebral hemorrhage
 DURATION _____
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations None
 Date of op. _____
 Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide None Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE S. Robert Wells DEPUTY MEDICAL EXAM.
Hagerstown, Md. WASH. CO., MD.
 M. D. 11/7/47
 Address _____ Date signed _____

RECEIVED
NOV 10 1947
BUREAU

Birth and Death 10410
159

Reg. Dist. No. 302

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF STILLBIRTH

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Washington
City or town Hagerstown, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street address, hospital, or institution:
Washington County Hospital
Length of mother's stay in County _____
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 844 Marshall St.
(If RURAL give LOCATION)

3. Name of child Baby Girl Kay
5. Sex female 6. Twin or tripled _____

4. Date of birth Nov. 10 1947 Hour 2:53 P.M.
7. No. of weeks pregnancy 5

FATHER OF CHILD

8. Full name Charles Broude H Kay
9. Color W 10. Age at time of this birth 26 yrs.
11. Usual occupation Shoe Worker

MOTHER OF CHILD

12. Full maiden name Lillian Dorothy Hinkle
13. Color W 14. Age at time of this birth 24 yrs.
15. Usual occupation House wife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0
(b) How many other children were born alive but are now dead? _____ (c) How many other children were born dead? 0

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of _____

19. Labor: (a) Complications of _____
(b) Induced? _____

20. (a) Was there an operation for delivery? No
(b) State all operations, if any _____
(Yes or No)

(c) Did child die before operation? _____
During operation? _____

23. (a) BURIAL (b) Date thereof 11/11/47
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory ROSE HILL Cemetery

24. (a) Funeral director ANDREW K. Goffman
(b) Address Hagerstown, Md.

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes _____
(b) Maternal causes unknown

22. I certify to the birth of this child who was born ~~dead~~ on the date and hour above stated.

Signature W. D. [illegible]
(Specify if M. D., midwife, or other)

Address Hagerstown, Md.

25. (a) Nov. 11, 1947 (b) Chas. H. Bowers
(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)
The above certificate has been examined by me.

Health Officer, per _____

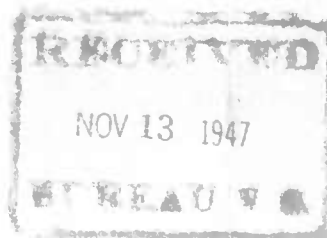
* See Instruction C on stub.

Child Lived 1 hr - 52 minutes

I

V. S. A10

T



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WASHINGTON
 City or town HAGERSTOWN
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 YRS.

Hospital, institution, or street address where death occurred:
WASHINGTON COUNTY HOSPITAL

How long in hospital or institution? 42 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County WASHINGTON

City or town HAGERSTOWN
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 137 JOHN STREET
 (If rural, give LOCATION)

2.(a) If veteran, name war NON-VET.

3.(a) FULL NAME

MAZIE BRYAN KENDALL

3.(b) Social Security Number

NONE

4. Sex

FEMALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife ROY L. KENDALL

6.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) MAY, 8, 1898

8. AGE: 49 Years 6 Months 3 Days hrs. min.

9. Birthplace INWOOD, BERKLEY, W. VA.
 (Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name CHARLES L. BUTLER

13. Birthplace DARKSVILLE W. VA.

14. Maiden name ANNA MARY KISNER

15. Birthplace HANCOCK MD.

16. Informant Roy L. Kendall

Address 137 John St.

17. Burial Date thereof 11/13/47
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rose Hill

Location Hagerstown, Md.

18. Funeral director Woodford J. Norment

Address Hagerstown, Md.

19. Nov. 12, 47 Registrar Clayton

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11, 1947 at 12:00 A. M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from August 2, 1945 to November 11, 47

and that I last saw h. 27 alive on November 10, 1947

Immediate cause of death Carcinoma of uterus. DURATION 16 mos.

Due to

Due to

Other conditions Cachexia of malignancy

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. none

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

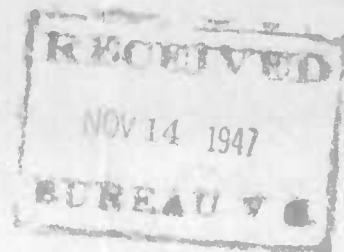
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE RB Norment M.D. M. D. or other

Address Hagerstown Md Date signed 11/12/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

10412

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 years
 Hospital, institution, or street address where death occurred:
315 West Side Ave.
 How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 315 West Side Ave.
 (If rural, give LOCATION)
 2(a) If veteran, name war World War 2 -

3. (a) FULL NAME

Jennings - m - Kline

3. (b) Social Security Number

175-10-9735

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Frances Metz Kline

7. Birth date of deceased (mo., day, yr.)

November 2 - 1908

8. AGE:

3908

It less than one day

hrs.min.

9. Birthplace

Westport md.
(town, county, and state)

10. Usual occupation

Sheet metal Worker

11. Industry or business

Pangborn Corp.

FATHER

12. Name

John W. Kline

13. Birthplace

Virginia

MOTHER

14. Maiden name

Sarah Kline

15. Birthplace

Virginia

16. Informant

Mrs. Frances Metz Kline

Address

315 West Side Ave. Washington

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Nov. 12, 1947
(month) (day) (year)

Cemetery or crematory

Manor Cemetery

Location

near Takoma Park Md.

18. Funeral director

Wm. J. Bost & Sons

Address

Boonslow Md.

19. Nov. 11, 1947

(Date rec'd by registrar)

19

Charles H. Powers
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov / 10 / 47 19 12:50A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....
and that I last saw him.....alive on.....19.....

Immediate cause of death

coronary occlusion

DURATION

8d

Due to

acute coronary occlusion

Due to

(2nd occlusion)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

S. Robert Wells
Wagerstown, Md.

DEPUTY MEDICAL EXAM.

WASH. CO., MD.

M. D. or

Address

Date signed

Nov. 11-47

RECEIVED

NOV 13 1947

STRAUS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *1860* *BC* *10412* *306*

1. PLACE OF DEATH:

County *Washington*

City or town *Croftside*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *since Sept 23, 1947*

Hospital, institution, or street address where death occurred:

Pitcher Hospital

How long in hospital or institution? *since Sept 23, 1947*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Prince Georges*

City or town *Baltimore*
(If outside city or town limits, write RURAL and give nearest town)

Street No. *3020 Finby St.*
(If rural, give LOCATION)

2.(a) If veteran, name war *✓*

3. (a) FULL NAME

Rufus Lavender

3. (b) Social Security Number

4. Sex *male* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *Divorced*

6. (b) Name of husband or wife *Sorothy M. Lavender*

5. (c) If alive, give age *47* years

7. Birth date of deceased (mo., day, yr.) *April 9, 1907*

8. AGE: Years *40* Months *6* Days *23* If less than one day *hrs. min.*

9. Birthplace *Virginia*
(Town, county, and state)

10. Usual occupation *Bank Teller*

11. Industry or business

12. Name *Samuel H. Lavender*

13. Birthplace *Virginia*

14. Maiden name *Maudie A. Bowles*

15. Birthplace *Virginia*

16. Informant *Mrs. Hazel O'Malley*

Address *3020 Finby St.*

17. *Burial* Date thereof *Nov 5, 1947*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Oakwood*

Location *Richmond, Va.*

18. Funeral director *Chenoweth & Sonoran*

Address *3615-17 Chestnut Ave.*

19. *Nov 3 1947* *X W Hedrich*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Nov 2* 19 *47*, at *11:30 P.* M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Sept 23* 19 *47*, to *Nov 2* 19 *47*

and that I last saw him alive on *Nov 2* 19 *47*

Immediate cause of death *Acute pyelonephritis with septicemia*

DURATION *1 mo. 3 days*

Due to

Due to

Other conditions *Paraplegia due to compression fracture 10th thoracic vertebra*
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Accident* Date of *Feb. 4, 1947*

Where did injury occur? *1700 N. Chas. St. Balto. Md.*
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) *Martin J. Barry Co.*

Means of Injury *Fell down open elevator shaft.* Injured at work? *no*

23. SIGNATURE *Thomas M. Arrington* M.D. or other *M.D.*

Address *Pitcher Hospital* Date signed *Nov 3, 1947*

Croftside, Md.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10414

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
419 West Franklin St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 419 West Franklin St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Anna Battle Lee

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Philip L. Lee
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years About 60 Months Days It less than one day hrs. min.

9. Birthplace Hagerstown, Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Home Duties

11. Industry or business

12. Name Michael Battle

13. Birthplace Unk.

14. Maiden name Mary Larkin

15. Birthplace Unk.

16. Informant Philip L. Lee

Address Jamacia British W. Indies

17. Burial Date thereof Nov. 21, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Maryland

18. Funeral director Fred W. Kraiss

Address Hagerstown, Maryland

19. Nov. 20, 1947 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov/9/47 about 5 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death acute alcoholic narcosis

Due to chr. alcoholism

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results yes as above 4/12

PHYSICIAN: Please underline the cause to which death should be charged statistically. 47

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Robert Wells DEPUTY MEDICAL EXAM.

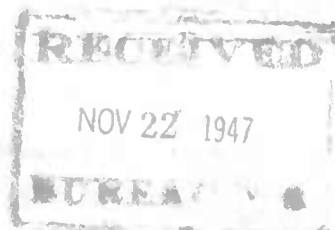
Hagerstown, Md. WASH. CO. MD.

Address Date signed Nov. 20, 47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10415

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 8 years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution?..... 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 31 South Prospect Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Caro A. Lyon

3. (b) Social Security Number

NONE

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Widow
 6.(b) Name of husband or wife..... Charles L. Lyon
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... March 1, 1865
 8. AGE: Year..... 82 Month..... 8 Day..... 5 If less than one day..... hrs. min.

9. Birthplace..... New Haven, Conn.
(Town, county, and state)10. Usual occupation..... Retired

11. Industry or business

12. Name..... Heman B. Allen
 13. Birthplace..... New Haven, Conn.

14. Maiden name..... Margaret E. Ferguson
 15. Birthplace..... Attleboro, Mass.

18. Informant..... Charles D. Lyon
 Address..... Hagerstown, Maryland

17. Removal Date thereof..... 11-7-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Walnut Grove Cemetery
 Location..... Meriden, Conn.

18. Funeral director..... C. M. Suter & Sons
 Address..... Hagerstown, Maryland

19. Nov 6, 47 Blasf. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov 6, 1947 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct 6, 1947 to Nov 6, 1947
 and that I last saw him alive on Nov 6, 1947

Immediate cause of death..... Cardio-vascular
renal disease. DURATION..... (?)

Due to.....

Due to.....

Other conditions..... Acute Pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... W. Campbell M. D. or otherAddress..... Hagerstown Md. Date signed..... 11/6-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Mark correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

1. USUAL RES.

1. PLACE OF DEATH

City or town _____
 How long in room since ill death? _____
 How long in room since death? _____
 How long in room since death? _____
 How long in room since death? _____
 How long in room since death? _____

2. FULL NAME

3. SEX 4. AGE 5. DATE OF BIRTH

6. PLACE OF BIRTH 7. PLACE OF DEATH 8. DATE OF DEATH 9. CAUSE OF DEATH 10. MANNER OF DEATH 11. SIGNATURE OF PHYSICIAN 12. SIGNATURE OF REGISTRAR 13. SIGNATURE OF WITNESS 14. SIGNATURE OF WITNESS 15. SIGNATURE OF WITNESS 16. SIGNATURE OF WITNESS 17. SIGNATURE OF WITNESS 18. SIGNATURE OF WITNESS 19. SIGNATURE OF WITNESS 20. SIGNATURE OF WITNESS

RECEIVED
 NOV 8 1947
 BUREAU

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, MARYLAND STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.

THIS COPY IS RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

10416

300

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:

County... WashingtonCity or town... Rural--Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Rural--Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Mary M. Marshall

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

MEDICAL CERTIFICATION

2D. DATE OF DEATH... Nov. 16 19 47, at 2:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 19 47 to Nov. 16 19 47
and that I last saw him alive on Nov. 15 19 47

Immediate cause of death...

Paroxysm

DURATION

1 monthDue to... Chronic Arterioscleroticand malignant hypertension2 years

Due to...

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter H. Shaly M.D.Sharpsburg, Md M. D. or otherAddress... Date signed 11/17/478. (b) Name of husband or wife... Edward Marshall--Deceased

B. (c) If alive, give age

7. Birth date of

deceased (mo., day, yr.)

April 25, 1882

8. AGE:

Years

65

Months

6

Days

21

If less than one day

.....hrs.min.

9. Birthplace Keedysville-Washington-Maryland

(Town, county, and state)

10. Usual occupation... Home Duties

11. Industry or business

12. Name... Frederick Holmes13. Birthplace Keedysville, Md14. Maiden name... Unknown

15. Birthplace

16. Informant... Leon EbersoleAddress Rural--Sharpsburg, Md17. Burial Date thereof... Nov. 18, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory... Mt. ViewLocation... Sharpsburg, Md18. Funeral director... R. I. EarnshawAddress Keedysville, Md19. 11/18/47 19 47
(Date rec'd by registrar) Registrar E. H. Beyer

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

10417

302

1. PLACE OF DEATH: Washington
 County Agrestown
 City or town Agrestown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? seven days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Agrestown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 314 N. Jonathan Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME Polly Jane Mc Intosh

3. (b) Social Security Number

None

4. Sex Female 5. Color or race Negro (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Lucius Mc Intosh
 7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years 37 Months _____ Days _____ If less than one day _____ hrs. _____ min.

8. Birthplace Rockingham, Richmond, N. C.
 (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

12. Name Charles Leak
 13. Birthplace Rockingham, N. C.
 14. Maiden name Maggie Adams
 15. Birthplace South Carolina

16. Informant Mrs. Lillian Ellerbee
 Address 1000 E. Washington St., Rockingham N.C.

17. Burial. Date thereof 11/7/47
 (Burial, cremation, or removal. Which? (month) (day) (year))

Cemetery or crematory Rose Hill Cemetery
 Location Agrestown, Md.

18. Funeral director William H. Downey
 Address 291 Frederick St. Agrestown

19. Nov. 7, 1947
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4th 19 47 at 11:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 30th 19 47 to Nov. 4th 19 47
 and that I last saw him alive on Nov. 4th 19 47

Immediate cause of death Occlusion of the coronary artery

DURATION

5 wks.

Due to Syphilitic aortitis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of

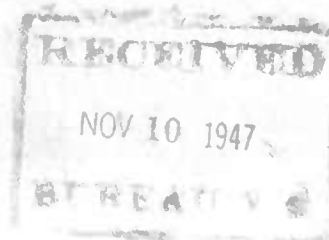
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Phyllis W. Adams MD.

Address 159 N. Washington St. Date signed 11/7/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Dr. Novenstein

10418

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 1/2 Days
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 2 1/2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 714 West Franklin St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

MRS ELIZABETH MOATS

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife Hiram O.
 6.(c) If alive, give age - years
 7. Birth date of deceased (mo., day, yr.) May 7 1867
 8. AGE: Years 80 Months 6 Days 10 If less than one day - hrs. - min.

9. Birthplace Fairplay Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home
 12. Name Samuel Kit Miller
 13. Birthplace Fairplay Md.
 14. Maiden name Rachael Richard
 15. Birthplace Martinsburg W. Va.

16. Informant Mrs. Max Weaver
 Address Hagerstown Md.
 17. Burial Date thereof 11/19/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Manor Cemetery
 Location near Tilghmanton Md.
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Nov. 17. 47
 (Date rec'd by registrar) Registrar Dr. H. B. Bowers

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1947 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6 1947 to Nov. 17 1947 and that I last saw him alive on November 16 1947

Immediate cause of death Hypertensive Cardio-vascular disease

DURATION

Due to -
 Due to -
 Other conditions -

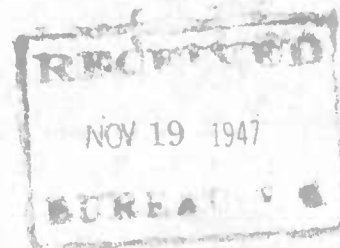
(Include pregnancy within 8 months of death)

Major findings of operations -
 Date of op. -

Autopsy results -
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide - Date of -
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury - Injured at work?

23. SIGNATURE Sidney Novenstein MD
 M. D. or other -
 Address Suburban Md Date signed 11-17-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

10420

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
1030 Main Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1030 Main Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Nanny Florence Montgomery

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife John F. Montgomery
~~None~~ 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, year) November 9, 1876
 8. AGE: Years 71 Months 0 Days 3 It less than one day
 hrs. min.

9. Birthplace Washington County Maryland
 (Town, county, and state)
 10. Usual occupation Home Duties
 11. Industry or business

MOTHER FATHER
 12. Name William Wade
 13. Birthplace Washington Co. Md.
 14. Maiden name Roseanna
 15. Birthplace Unknown

16. Informant Dr. Daniel Montgomery
 Address 1030 Main Ave. Hagerstown, Md.

17. Burial Date thereof Nov. 16, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Smithburg Cemetery
 Location Smithburg, Maryland

18. Funeral director Fred W. Kraiss
 Address Hagerstown, Maryland

19. Nov. 16 19 47 Blair Flowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 19 47 at 11 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov 12 19 47 to Nov 12 19 47
 and that I last saw him alive on Nov 12 19 47

Immediate cause of death Bronchial pneumonia DURATION 11-12 hrs

Due to

Due to Aureular infection 6 yrs +
 Other conditions Hypertension 6 yrs +
Diabetes mellitus 5 yrs +
 (Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results None Date of op.
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, pub'c place (where?)
 Means of injury Injured at work?

23. SIGNATURE W. J. Layman, M.D. M. D. or other
Hagerstown Md Date signed 14 Nov 1947

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2071 Johnson, 1964

REPORTED

NOV 18 1947

TREAU 4 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct cause is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1041303

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 weeks
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Big Pool
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Elizabeth Bowers Moore

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

George H. Moore

7. Birth date of deceased (mo., day, yr.)

March 30, 1876

6. (c) If alive, give age _____ years

8. AGE:

71 Years7 Months26 Days

If less than one day

_____ hrs. _____ min.

9. Birthplace

Big Spring - Wash. co. Md.
(Town, county, and state)

10. Usual occupation

Home Duties

11. Industry or business

FATHER
MOTHER

12. Name

James Bowers

13. Birthplace

Unknown

14. Maiden name

Susan Shetz

15. Birthplace

Unknown

16. Informant

Miss Hilda Moore

Address

Big Pool, Md.

17.

Burial

Date thereof

Nov. 27, 1947
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Shanktown Cemetery

Location

Shanktown, Md.

18. Funeral director

Snyder-Rowland Funeral Home

Address

Hancock, Md.Nov 27
(Date rec'd by registrar)1947Joseph W. Murray
Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Nov. 25, 1947 19 6:45 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 1, 1947 to Nov. 25, 1947
and that I last saw her alive on Nov. 24, 1947

Immediate cause of death

DURATION

Cerebral Sclerosis1 mo.

Due to

Arterio Sclerosis5 yrs.

Due to

Other conditions

Diabetes Insipidus
(Include pregnancy within 8 months of death)6 mo

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

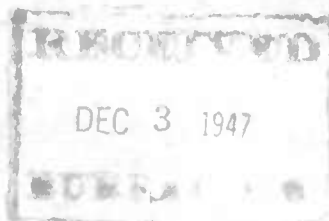
23. SIGNATURE

David P. Brewer M.D.

M. D. or other

Address

Clear Spring Md.Date signed 11/25/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1043103

1. PLACE OF DEATH:

County Washington
 City or town Charlton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Charlton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2. (a) if veteran, name war

3. (a) FULL NAME

Fannie Laura Myers

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Calvin M. Myers
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Sept. 12, 1885
 8. AGE: Years 62 Months 2 Days 8 It less than one day _____ hrs. _____ min.

9. Birthplace Clearsprings, Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Home duties

11. Industry or business

12. Name John D. Miles
 13. Birthplace Virginia
 14. Maiden name Amanda Bowers
 15. Birthplace Virginia

16. Informant Mr. Calvin M. Myers
 Address Charlton, Maryland

17. Burial Date thereof Nov. 22, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Pauls Cemetery
 Location Western Pike, Md.

18. Funeral director Snyder-Rowland Funeral Home
 Address Clearsprings, Maryland

19. Nov 22 1947 Joseph Murray Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1947 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1940 to Nov 19 1947
 and that I last saw him alive on Nov. 19 1947

Immediate cause of death Cerebral Hemorrhage DURATION 3 days

Due to Arterio Sclerosis 10 yrs.

Due to _____

Due to _____

Other conditions Pu Deleux 10 yrs.
Ruptured Vertebral Disc 4 yrs.
 (Include pregnancy within 8 months of death)

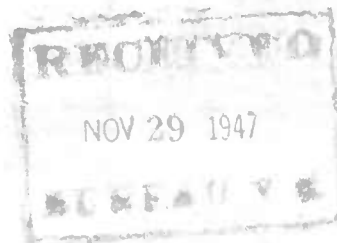
Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE David P. Brewer M.D. M. D. or other _____
Clear Spring Md Address _____ Date signed 11/22/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH:

County Washington
 City or town Big Spring
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 months
 Hospital, institution, or street address where death occurred:
Big Spring
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Harlow
 City or town Big Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 13th
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Samuel Royer Nichols

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Mary E. Nichols

7. Birth date of deceased (mo., day, yr.) May 3, 1874 6.(c) If alive, give age _____ years

8. AGE: Years 73 Months 6 Days 15 If less than one day _____ hrs. _____ min.

9. Birthplace Cascade-Hodg. Md.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Augustus Nichols

13. Birthplace Cascade, Md.

14. Maiden name Susan Royer

15. Birthplace Cascade, Md.

16. Informant Miss Clarence Ferguson

Address Baltimore, Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Nov. 20, 1947
 (month) (day) (year)

Cemetery or crematory Bethel Cemetery

Location Blue Ridge Summit, Md.

18. Funeral director Walter J. Grose

Address Haymarket, Pa.

19. Nov 19 19 47 Joseph W. Murray Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 19 47, at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APRIL 12 19 47, to NOV. 17 19 47
 and that I last saw him alive on SEPT. 6 19 47

Immediate cause of death CORONARY OCCLUSION
ACUTE DURATION 1/2 hr.

Due to Myocarditis, chronic

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations NONE

Date of op.

Autopsy results NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur Robert Cohen M. D.

Address Clea Spring, Md. Date signed Nov. 18/47

NAVY AND AIR FORCE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

NOV 21 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10423

302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

217 Norway Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 217 Norway Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John Huss Patterson

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 6, 1857

8. AGE:

Years

90

Months

4

Days

19

If less than one day

hrs.

min.

9. Birthplace Franklin County Penna.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
MOTHER

12. Name Joseph Patterson

13. Birthplace Penna.

14. Maiden name Elizabeth Weitich

15. Birthplace Germany

16. Informant Mrs. Alvey Strock

Address 217 Norway Ave. Hagerstown, Md.

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Nov. 28, 1947
(month) (day) (year)

Cemetery or crematory St. Thomas Cemetery

Location St. Thomas, Penna.

18. Funeral director Barbour Funeral Home

Address Chambersburg, Penna.

19. Nov 26, 1947
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24, 1947 at 9:15 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to November 1947 and that I last saw him alive on November 24, 1947

Immediate cause of death Chronic Nephritis

DURATION

2 yrs.

Due to

Due to

Other conditions General Arteriosclerosis ind.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE B. Strock M. D. or other

Address 148 W. Washington St. Date signed Nov, 26

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 28 1947

BY SEA 15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1220 10424 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 5 weeks
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution?..... 5 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington
 City or town..... Keedysville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Charles Lewis Perkins

3. (b) Social Security Number

None

4. Sex..... Male
 5. Color or race..... White
 6.(a) Single, married, widowed, or divorced..... Married
 6.(b) Name of husband or wife..... Mrs. Viola Perkins
 6.(c) If alive, give age..... 74 years
 7. Birth date of deceased (mo., day, yr.)..... Dec. 17, 1872
 8. AGE: Years..... 74 Months..... 10 Days..... 27
 If less than one day..... hrs. min.

9. Birthplace..... Lynchburg-Virginia
 (Town, county, and state)
 10. Usual occupation..... None
 11. Industry or business.....

12. Name..... Lewis Perkins
 13. Birthplace..... Lynchburg--Virginia
 14. Maiden name..... Mildred May
 15. Birthplace..... Lynchburg--Virginia
 16. Informant..... Mrs. Viola Perkins
 Address..... Keedysville, Md

17. Burial..... Date thereof..... Nov. 16, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Funkstown
 Location..... Funkstown, Md.
 18. Funeral director..... R. I. Earnshaw
 Address..... Keedysville, Md
 19. Nov. 14, 47 Chas. H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov. 13, 1947, at 3:35 P. M.

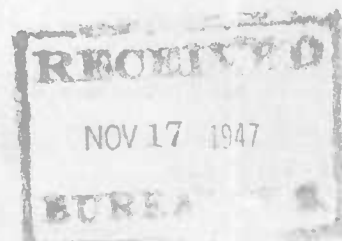
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 9, 1947, to Nov. 13, 1947
 and that I last saw him alive on October 12, 1947

Immediate cause of death.....
Chronic Myocarditis
 Due to.....
 Due to.....
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Two suppurated wounds of colon..... Date of op. Oct. 9, 1947
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....
 23. SIGNATURE..... J. W. Bowers M.D.
 Address..... Keedysville..... Date signed..... 11/14/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10425

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
Washington County Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Hagerstown Route #4
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

George W. Phillips

3. (b) Social Security Number

NONE

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male

White

Widower

6. (b) Name of husband or wife Blanche S. Phillips

7. Birth date of deceased (mo., day, yr.) April 15, 1865

8. AGE: Years Months Days If less than one day

82

7

2

hrs.

min.

9. Birthplace Luray, Virginia
(Town, county, and state)

10. Usual occupation Retired Laborer

11. Industry or business

12. Name Not Known

13. Birthplace Not Known

14. Maiden name Not Known

15. Birthplace Not Known

16. Informant Robert Lichliter

Address Luray, Va.

17. Burial Date thereof 11-19-47
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Green Hill Cemetery

Location Luray, Va.

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. Nov 17 19 47 Class. H. Bowler
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 19 47 at 2⁰⁰ P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 17 19 47 to Nov. 17 19 47

and that I last saw him alive on Nov. 19 47

Immediate cause of death

DURATION

Coronary Occlusion 1 day.

Due to Hypertension 2 yrs.

Due to Chronic atherosclerosis 2 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results
PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE Ernest J. Pollock M. D. or Other

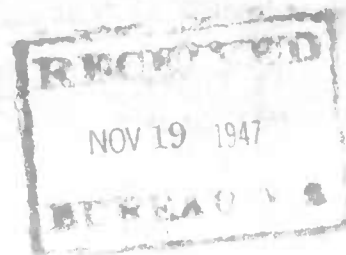
Address Hagerstown Md. Date signed 11/17/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:

County Washington County
 City or town Williamsport, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 month
 Hospital, institution, or street address where death occurred:
21 N. Vermont St. Williamsport, Md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Williamsport, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 21 Vermont Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Charles Blucker Potts

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Florence Hoffman Potts
 7. Birth date of deceased (mo., day, yr.) Nov. 3 1907
 6. (c) If alive, give age 36 years
 8. AGE: Years 39 Months 24 Days 29 If less than one day hrs. min.

9. Birthplace Williamsport, Md.
 (Town, county, and state)
 10. Usual occupation Ice Cream Factory
Hershey Ice Cream
 11. Industry or business

FATHER 12. Name George Potts
 13. Birthplace Williamsport Md.
 MOTHER 14. Maiden name Elizabeth Harsh
 15. Birthplace Williamsport, Md.

16. Informant Florence Hoffman Potts
 Address Williamsport, Md. RFD #1

17. Burial Nov. 4 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Pauls Cemetery
 Location Near Clearspring Md.

18. Funeral director Edith V. Leaf
 Address #7 Church St. Williamsport, Md.

19. 11/4 47 Mrs. E. Lee McElroy
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

About

20. DATE OF DEATH Nov/1/47 19..... 21..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19..... to 19.....
 and that I last saw him alive on 19.....

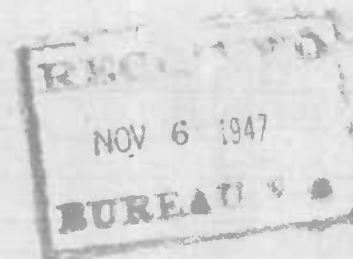
Immediate cause of death DURATION
 Due to Charring burn to
entire body
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations no
 Date of op.

Autopsy results no
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide accident Date of Nov/1/47
 Where did injury occur? Williamsport Wash. Md.
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where)? Home
 Set bed afire while smoking cigarette
 Means of injury smoking cigarette Injured at work? No

23. SIGNATURE Robert Thells DEPUTY MEDICAL EXAM
Robert Thells WASH. CO. MD.
 Address Williamsport, Md. M. D. or other
 Date signed 11/1/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Conrad

Reg. Dist. No. 3-6

1. PLACE OF DEATH:

County Washington
 City or town Breathedsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 Months
 Hospital, institution, or street address where death occurred:
Md. State Reformatory for Males
 How long in hospital or institution? 5 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County --
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 910 St. Barnabas Place
 (If rural, give LOCATION)
None
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

JAMES REED

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife --
 7. Birth date of deceased (mo., day, yr.) September 6 1925
 8. AGE: Years 22 Months 2 Days 8 If less than one day hrs. min.

9. Birthplace Baltimore City Maryland
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business --

12. Name Irving Reed
 13. Birthplace Baltimore Md.
 14. Maiden name Alverta Jones
 15. Birthplace Baltimore Md.

16. Informant Records of Md. State Ref. for Males
 Address Breathedsville Md.
 17. Burial Date thereof Nov. 17, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Md. State Reformatory Cem.
 Location Breathedsville. Md

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md

19. Nov. 17. 1947 John H. Baer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH November 14 1947 at 3.45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1947 to Nov 14 1947
 and that I last saw him alive on Nov 13 1947

Immediate cause of death Pulm Tuberculosis
 DURATION 9 mos.
 Due to ---
 Due to ---
 Other conditions ---
 (Include pregnancy within 3 months of death)

Major findings of operations --- Date of op. ---
 Autopsy results ---
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide --- Date of ---
 Where did injury occur? (City or town) (County) (State)
 injured at home, farm, industry, public place (where?)
 Means of injury --- Injured at work?
 23. SIGNATURE Robert P. Conrad, M.D.
 M. D. or other ---
 Address Hagerstown, Md Date signed 11-15-47

RECEIVED
NOV 22 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10428 302
Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Happans Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2400 R.I.
(If rural, give LOCATION)
2.(a) If veteran, name war No.

3. (a) FULL NAME

William Grimes Rhodes

3. (b) Social Security Number

- None -

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Ida Middlekamp Rhodes
5. (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) August 29 - 1870

8. AGE: Years 77 Months 2 Days 12 It less than one day hrs. min.

9. Birthplace Downsville Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Retired

12. Name Lewis B. Rhodes

13. Birthplace Emmitsburg Ind. Co. Md.

14. Maiden name Sarah J. Farthman

15. Birthplace Waynesboro Penna.

16. Informant Mrs. Ida M. Rhodes

Address Fairplay Md. R. 1

17. Burial Date thereof November 14, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bakersville Cemetery

Location Bakersville Md.

18. Funeral director Wm. J. Baer & Sons

Address Boonsboro Md.

19. Nov. 13, 47 Registrar Chas. Powers

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 - 1947 at 7:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 1947 to Nov 11 1947

and that I last saw him alive on November 11 1947

Immediate cause of death Uremia

Due to Benign Prostatic Hypertrophy

Due to 9

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of Nov 11, 1947

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) None

Means of injury None Injured at work? None

23. SIGNATURE L. H. Novak M. D. or other

Address 2400 R.I. Date signed 11-13-47

Registrar Chas. Powers

(Date rec'd by registrar)

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Novak

RECEIVED

NOV 15 1947

STRENGTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10429

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 43 years
 Hospital, institution, or street address where death occurred:
310 North Locust St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 310 North Locust St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Leonard J. Saylor

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mabel G. Saylor

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

May 5, 1888

8. AGE:

Years

Months

Days

If less than one day

59

6

19

hrs.

min.

9. Birthplace

Franklin Co., Penna.
(Town, county, and state)

10. Usual occupation

Retired Policeman

11. Industry or business

FATHER

12. Name

Abraham R. Saylor

13. Birthplace

Penna.

MOTHER

14. Maiden name

Alice Bower

15. Birthplace

Wash. Co. Maryland

16. Informant

Mrs. Mabel G. Saylor

Address 310 N. Locust St. Hagerstown, Md

17.

(Burial, cremation, or removal, Which?)

Date thereof

Nov. 26, 1947
(month) (day) (year)

Cemetery or crematory

Rest Haven Cemetery

Location

Hagerstown, Md.

18. Funeral director

Fred W. Kraiss

Address

Hagerstown, Md.

19.

(Date rec'd by registrar)

Nov. 26, 1947

Black, Bowers

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH. November 24, 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov. 9 1947 to Nov. 23 1947
 and that I last saw him alive on Nov. 23 1947

Immediate cause of death

Arteriosclerosis Heart Disease

DURATION

2 yrs.

Due to

Due to

Other conditions

Aneurysm of Aorta

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

F. W. Kraiss

M. D. or other

Address. Hagerstown, Md. Date signed 11/25/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 28 1947

61114 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10430

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington
Hagerstown
 City or town (If outside city or town limits, write RURAL and give nearest town) 2 week's
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
421 Jefferson St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 514 Quincy St. N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Sallie C. Semler

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife John D. Semler

7. Birth date of deceased (mo., day, yr.) October 25, 1867 6.(c) If alive, give age _____ years

8. AGE: Years 80 Months - Days 27 If less than one day _____ hr. _____ min.

9. Birthplace Smithsburg Wash. Md.
 (Town, county, and state)

10. Usual occupation None
 11. Industry or business None

FATHER 12. Name John Lum
 13. Birthplace England

MOTHER 14. Maiden name Rachael Gaul
 15. Birthplace Germany

16. Informant Mrs. Clyde Bowers
 Address Hagerstown Md.

17. Burial 11-25-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery
Hagerstown Md.
 Location Scott F. Minnich & Son

18. Funeral director Hagerstown Md.
 Address

19. Nov. 24, 47 Registrar Clyde Bowers
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 1947 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 12 1947 to November 22 1947 and that I last saw him alive on November 12 1947

Immediate cause of death Coronary occlusion DURATION instantaneous

Due to Arteriosclerotic heart disease with hypertrophy 10 years

Due to _____

Other conditions (Patient was dead on arrival)

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE B. B. Bowers M. D. or other

Address 148 W. Washington Street Date signed 11-24-47

RECORDED
NOV 26 1947
BUREAU V C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

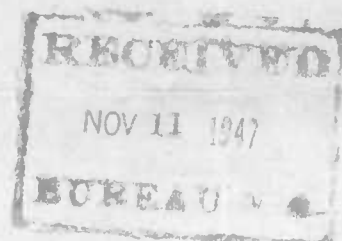
CERTIFICATE OF DEATH

Reg. Dist. No. 302

10431

1310

1. PLACE OF DEATH: County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>Unknown</u> Hospital, institution, or street address where death occurred: <u>482 Mitchell Ave.</u> How long in hospital or institution? <u>---</u>			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>482 Mitchell Ave.</u> (If rural, give LOCATION) 2.(a) If veteran, name war <u>---</u>		
3. (a) FULL NAME <u>Sally Shaffer</u>			3. (b) Social Security Number <u>---</u>		
4. Sex <u>Female</u> 5. Color or race <u>White</u> 6. (a) Single, married, widowed, or divorced <u>Widowed</u>			MEDICAL CERTIFICATION 20. DATE OF DEATH <u>November 8, 1947</u> <u>7:40a</u> <u>M</u> 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>19</u> to <u>19</u> and that I last saw him <u>alive</u> on <u>19</u> Immediate cause of death <u>Coronary Arteriosclerosis</u> <u>Cerebral Hemorrhage</u> Due to <u>Chr. glomerulonephritis</u> Other conditions <u>---</u> (Include pregnancy within 3 months of death) Major findings of operations <u>---</u> Autopsy results <u>no</u> PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide <u>no</u> Date of <u>---</u> Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury <u>---</u> Injured at work? <u>---</u> 23. SIGNATURE <u>S. Robert Wells</u> <u>Wash. Co. Md.</u> Address <u>Hagerstown Md.</u> Date signed <u>Nov. 9 '47</u>		
6. (b) Name of husband or wife <u>Taylor Shaffer</u> 6. (c) If alive, give age <u>---</u> years 7. Birth date of deceased (mo., day, yr.) <u>December 31, 1870</u> 8. AGE: Years <u>76</u> Months <u>11</u> Days <u>7</u> If less than one day <u>---</u> hrs. <u>---</u> min. 9. Birthplace <u>Unknown</u> (Town, county, and state) 10. Usual occupation <u>None</u> 11. Industry or business <u>None</u> MOTHER FATHER 12. Name <u>David Pampell</u> 13. Birthplace <u>Woodstock Va.</u> 14. Maiden name <u>Unknown</u> 15. Birthplace <u>Unknown</u> 16. Informant <u>Berton T. Shaffer</u> Address <u>Lanham Pa.</u> 17. Burial <u>11-10-47</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Rose Hill Cemetery</u> Location <u>Hagerstown Md.</u> 18. Funeral director <u>Scott F. Minnich & Son</u> Address <u>Hagerstown Md.</u> 19. Nov. 9. 47 <u>Shaffer Bowers</u> (Date rec'd by registrar) Registrar			DURATION <u>34</u> <u>3 yrs</u>		



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

10432

1. PLACE OF DEATH:

County WASHINGTON
 City or town HAGERSTOWN
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 DAYS
 Hospital, institution, or street address where death occurred:
WASHINGTON COUNTY HOSPITAL
 How long in hospital or institution? 11 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State PENNSYLVANIA County FRANKLIN
 City or town GREENCASTLE
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 219 E. FRANKLIN ST.
 (If rural, give LOCATION)
 2. (a) If veteran, name war NON-VET ✓

3. (a) FULL NAME

DORIS JEAN SHANK

3. (b) Social Security Number

NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced SINGLE

6. (b) Name of husband or wife

6. (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) APRIL 28, 1939

8. AGE: Years 8 Months 6 Days 23 If less than one day
 hrs. min.

9. Birthplace GREENCASTLE, FRANKLIN, PA.
(Town, county, and state)10. Usual occupation STUDENT11. Industry or business SCHOOL12. Name ROSS SHANK13. Birthplace SHADY GROVE PA.14. Maiden name ETHEL DREHL15. Birthplace GREENCASTLE, PA.16. Informant Ethel ShankAddress Greencastle Pa.17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 11/23/47
(month) (day) (year)Cemetery or crematory Cedar Hill Cem.Location Greencastle Pa.18. Funeral director Woodward J. HornumAddress Hagerstown Md.19. Nov. 21, 47 Registrar W. H. Robinson

(Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH Nov. 21 1947, at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov. 10 1947 to Nov 21 1947.
 and that I last saw him alive on Nov. 20 1947.

Immediate cause of death Acute Cardiac Failure DURATION 1 day.

Due to Intestinal Obstruction
Fecal. 1947.

Due to Megacolon (Hirschsprung's
DISEASE) CONGENITAL Since Birth.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

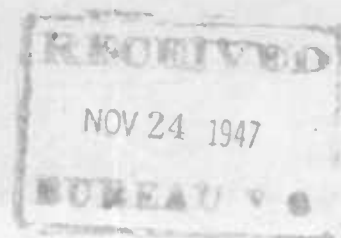
Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Robinson M. D. or otherAddress 2411 N. Robinson St. Date signed 11/21/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10433

Reg. Dist. No. 302

MY

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 days
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania County Franklin
 City or town Chambersburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 773 S. 2nd St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

John Shatzley

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Lizzie Wright Shatzley7. Birth date of deceased (mo., day, yr.) March 13, 1877

8. AGE: Years 70 Months 7 Days 22 If less than one day hrs. min.

9. Birthplace Franklin Co., Pa.
(Town, county, and state)10. Usual occupation Operator Seconhand Store

11. Industry or business

12. Name Simon Shatzley13. Birthplace Pennsylvania14. Maiden name Mary Boles15. Birthplace Pennsylvania16. Informant Mrs. Lizzie ShatzleyAddress 773 S. 2nd St. Chambersburg, Pa.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Nov. 8, 1947
(month) (day) (year)Cemetery or crematory Lincoln CemeteryLocation Chambersburg, Pa.18. Funeral director Perbourn Funeral HomeAddress Chambersburg, Pa.19. Nov. 6, 1947 Registrar Bluff Bourne

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5, 1947 at 8:05 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1947 to 1947and that I last saw him alive on 1947Immediate cause of death Cerebral concussionMultiple fractures of ribsDue to Closed fracture rt. ulnaand femurDue to Dislocation rt. footShock

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 11/3/47Where did injury occur? Hagerstown Wash. Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Middleburg PikeMeans of injury Auto collision Injured at work? No23. SIGNATURE S. P. Muller DEPUTY MEDICAL EXAM. WASH. CO., MD.Address Hagerstown, Md. Date signed 11/5/47

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NOV 8 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10434

1799

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 28 years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1105 Hamilton Blvd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Mary M. Shervin

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife..... 6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) October 31, 1872

8. AGE: Years 75 Months 0 Days 1 If less than one day..... hrs. min.

9. Birthplace Lappans, Wash. Co., Md.
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business.....

FATHER 12. Name Samuel E. Shervin
 13. Birthplace Washington County, Md.

MOTHER 14. Maiden name Elizabeth Knodle
 15. Birthplace Washington County, Maryland

16. Informant W. Hampton Shervin
 Address Hagerstown, Maryland

17. Burial Date thereof 11-4-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. Nov. 4, 47 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 19 47 at 11¹⁵ P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 23 19 47, to Nov 1 19 47
 and that I last saw him alive on Nov 1 19 47

Immediate cause of death Lye burn of mouth & throat DURATION 9 days
Accidental swallowing
of lye water

Other conditions Broncho-pneumonia 9 days
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Robert P. Conrad, M.D. M. D. or other
 Address Hagerstown, Md Date signed 11-3-47

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Country _____
 City or Town _____
 State _____
 Zip _____
 Name of the deceased _____
 Date of death _____
 Time of death _____
 Cause of death _____
 Manner of death _____
 Place of death _____

2. (a) FULL NAME

First name _____
 Middle name _____
 Last name _____
 Sex _____
 Date of birth _____
 Place of birth _____

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 NOV 7 1947
BUREAU

3. (b) SEX

4. (c) AGE

5. (d) OCCUPATION

6. (e) EDUCATION

7. (f) MARITAL STATUS

8. (g) RELIGION

9. (h) RACE

10. (i) COLOR

11. (j) BIRTH DATE

12. (k) BIRTH PLACE

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1046

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 37 N. Foundry St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Araminta M. Shrader

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1915 6.(c) If alive, give age years

8. AGE: Years 31 Months 11 Days 30 If less than one day
 hrs. min.

9. Birthplace Greencastle, Franklin Co. Pa.
 (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

12. Name John E. Shrader13. Birthplace Greencastle, Pa.14. Maiden name Ada G. Statler15. Birthplace Upton, Pa.16. Informant Mrs. Ada G. WilliamsAddress 37 N. Foundry St. Hagerstown, Md.

17. Burial Date thereof Nov. 14, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven CemeteryLocation Hagerstown, Md.18. Funeral director Fred W. KraissAddress Hagerstown, Md.

19. Nov. 13, 47 19 47
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 Nov 19 47, at 5:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
6 & Nov 19 47, to 11 Nov 19 47
 and that I last saw him alive on 10 & Nov 19 47

Immediate cause of death Cerebral Sinus Thrombosis
Meningitis DURATION 9 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edm. J. H. ...
 M. D. or other

Address Hagerstown Md. Date signed 12 Nov 47

MARGIN RESERVED FOR BINDING

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VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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NOV 15 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Brumbaugh

10436

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Weeks
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 3 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 407 Guilford Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

CHESTER MCKINLEY SMITH

3. (b) Social Security Number

212-14-7695

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower
 6.(b) Name of husband or wife Annie
 7. Birth date of deceased (mo., day, yr.) June 7 1898
 8. AGE: Years 49 Months 4 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Myersville Fred Co. Md.
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business Md. Machine & Foundry Wks.

12. Name Oliver M. Smith
 13. Birthplace Myersville Md.
 14. Maiden name Annie Green
 15. Birthplace Myersville Md.

16. Informant Mrs. Annie G? Smith
 Address Hagerstown Md.

17. Burial Date thereof 11/8/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Nov. 8. 19 47 Dr. Brumbaugh
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1947 19____ at 10 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/18/47 19____ to 11/6/47 19____
 and that I last saw him alive on 11/6/47 19____

Immediate cause of death Adeno Carcinoma right parotid gland with general Metastasis. Involvement of brain. DURATION Uncertain
 Due to Carcinoma saw first 6/18/47

Due to _____
 Other conditions _____

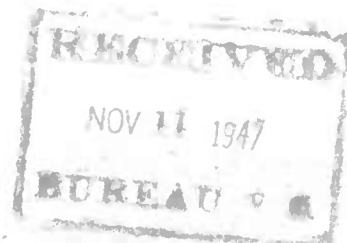
(Include pregnancy within 3 months of death)

Major findings of operations Same as above
 Date of op. 8/28/47

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Dr. Brumbaugh M. D. or _____
 Address _____ Date signed 11/8/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

Reg. Dist. No. 302

10437

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Washington Co. Hospital
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 644 N. Locust
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Connie Mae Smith

3. (b) Social Security Number

None

4. Sex

F.

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Nov. 4th 1947

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

18

hrs.

min.

9. Birthplace

Washington Co Hospital

(Town, county, and state)

10. Usual residence

Hagerstown Md.

11. Industry or business

MOTHER

12. Name

James C. Smith

13. Birthplace

Waynesboro Pa.

14. Maiden name

Dorothea Balcom

15. Birthplace

Hagerstown Md.

16. Informant

James C. Smith

Address

644 N Locust St. City

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Nov. 24th 1947

Cemetery or crematory

Rest Haven Cemetery

Location

Hagerstown Md.

18. Funeral director

L. F. Pucher

Address

Hagerstown Md.

19. (Date rec'd by registrar)

Nov. 24. 19 47

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Nov 19 47 at 5:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4 Nov19 47, to 22 Nov19 47and that I last saw h. 22 Nov alive on 22 Nov 19 47

Immediate cause of death

Pneumonia, bronchitis
(If fatal, give cause)

DURATION

5 days

Due to

Due to

Other conditions

Pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

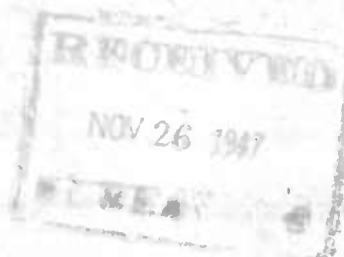
23. SIGNATURE

Edna S. H. Vackovich M.D.

M. D. or other

Address

Hagerstown Md.Date signed 11/23/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10438 301

1. PLACE OF DEATH:

County Washington
City or town R.F.D. Sharpsburg RFD#1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 Years
Hospital, institution, or street address where death occurred:
RFD #1 Sharpsburg
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town RFD#1 Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. RFD#1 Sharpsburg near dam #4
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Hazel May Smith
4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

3. (b) Social Security Number

None

6.(b) Name of husband or wife Ralph Smith
6.(c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1911

8. AGE: Years 36 Months 8 Days 25 If less than one day
.....hrs.min.

9. Birthplace Downsville, Washington, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At home

FATHER 12. Name Don't Know
13. Birthplace Don't Know

MOTHER 14. Maiden name Effie Cline
15. Birthplace Washington County, Maryland

16. Informant Ralph Smith
Address RFD#1 Sharpsburg, Maryland

17. Burial Date thereof Nov. 9, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Greenlawn Cemetery
Williamsport, Maryland
Location

18. Funeral director Edith V. Leaf
Address Williamsport, Maryland

19. Nov. 9 19 47 Mrs. E. Lee W. Elvey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1947 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/6/47 to 11/6/47 and that I last saw him alive on Nov 6 19 47

Immediate cause of death Acute Heart Failure

Due to Urinary insufficiency due to Rheumatic Endocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Ralph Elvey M. D. or other
Williamsport, Md. Date signed 11/8/47
Address

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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NOV 12 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County: Washington
City or town: Mt. Lema Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Boonsboro Route - 2 -
at Home.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington
City or town: Mt. Lema - Rural
(If outside city or town limits, write RURAL and give nearest town)Street No.: Boonsboro md. R. 2
(If rural, give LOCATION)

2.(a) If veteran, name war: No.

3. (a) FULL NAME

Helia Stouffer

3. (b) Social Security Number

None.

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Elmer Stouffer

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

September - 28 - 1871

8. AGE:

Years

Months

Days

If less than one day

76

1

8

hrs.

min.

9. Birthplace

Mt. Lema Wash. Co. md.
(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

Own Home.

FATHER

12. Name

William Irving

13. Birthplace

Wash. Co. Md.

MOTHER

14. Maiden name

Catherine Sage

15. Birthplace

Wash. Co. Md.

16. Informant

Elmer Stouffer

Address

Boonsboro md. R. 2

17.

(Burial, cremation, or removal. Which?)

Date thereof

Nov. 10. 1947
(month) (day) (year)

Cemetery or crematory

Mt. Lema Union Cemetery

Location

Mt. Lema md.

18. Funeral director

Ouy D. East & Sons

Address

Boonsboro md.

19.

(Date rec'd by registrar)

19

47

John H. East

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November - 6 - 19 47 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 29 19 47 to 6 Nov 19 47

and that I last saw him alive on 6 Nov 19 47

Immediate cause of death

Pneumonia, bronchitis (11/4/47 also)

DURATION

4 days

Due to

Due to

Other conditions

Aspiration

Not Known

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Edm. H. East

M. D. or other

Address: Hagerstown md. Date signed: 8 Nov 47

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BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Conrad

10440

BC
Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
 City or town Breathedsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 Months
 Hospital, institution, or street address where death occurred:
Md. State reformatory for Males
 How long in hospital or institution? 8 Mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County --
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 710 So. Hanover St
 (If rural, give LOCATION)
 2. (a) If veteran, name war None ✓

3. (a) FULL NAME

JAMES THORNTON

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife --
 7. Birth date of deceased (mo., day, yr.) November 2 1930
 8. AGE: Years 17 Months 0 Days 12 It less than one day hrs. min.
 6. (c) If alive, give age -- years

9. Birthplace Baltimore city Maryland
 (Town, county, and state)
 10. Usual occupation Porter
 11. Industry or business Laborer
 12. Name James Thornton Sr.
 13. Birthplace Virginia
 14. Maiden name Orphelia Coleman
 15. Birthplace No. Carolina

16. Informant Records of Md. State Ref. for Males
 Address Breathedsville Md.
 17. Burial Burial Date thereof 11/18/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mt. Calvary Cemetery
 Location Anne Arundle Co. Md.
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Nov. 15 19 47 John H. Bant
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

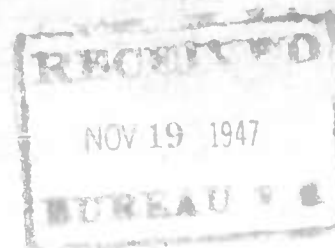
20. DATE OF DEATH November 14 1947 19 47, at 10.30 P
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 19 47, to Nov 14 19 47
 and that I last saw him alive on Nov 14 19 47

Immediate cause of death Pulm. Tuberculosis
 DURATION 4 mo.

Due to ---
 Due to ---
 Other conditions ---
 (Include pregnancy within 3 months of death)

Major findings of operations --- Date of op. ---
 Autopsy results ---
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide --- Date of ---
 Where did injury occur? --- (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) ---
 Manner of injury --- Injured at work? ---
 23. SIGNATURE Robert P. Conrad, M.D.
 M. D. or other ---
 Address Hagerstown, Md Date signed 11-15-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

10441

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington
 City or town... Keedysville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Valerie Lynn Wade

3. (b) Social Security Number

None

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Single</u>
6.(b) Name of husband or wife		
7. Birth date of deceased (mo., day, yr.) <u>Nov. 2, 1947</u>		
8. AGE: Years Months Days If less than one day		
<u>14</u> hrs. min.		

9. Birthplace... Martinsburg--West Virginia
(Town, county, and state)10. Usual occupation... None

11. Industry or business

12. Name... Unknown

13. Birthplace

14. Maiden name... Phyllis Wade15. Birthplace... Trego, Maryland16. Informant... Mr. Elmer WadeAddress... Keedysville, Maryland17. Burial Date thereof... Nov. 18, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Locust GroveLocation... Locust Grove--Md18. Funeral director... R. I. EarnshawAddress... Keedysville, Md19. Nov. 17, 1947 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Nov. 16 19 47 at 4:06 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/16 19 47 to 11/16 19 47 and that I last saw him alive on 11/16 19 47Immediate cause of death... Cerebral Hemorrhage DURATIONDue to... Asphyxia

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Chas H Bowers M. D. or otherAddress... Hagerstown, Md Date signed 11/17/47

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10442

Reg. Dist. No. 302

1. PLACE OF DEATH County..... <u>Washington</u> City or town..... <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>36 years</u> Hospital, institution, or street address where death occurred: <u>Washington County Hospital</u> How long in hospital or institution?..... <u>8 weeks</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Washington</u> City or town..... <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>16 Berner Avenue</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>Agnes Pearl Wolfensberger</u>				3. (b) Social Security Number <u>215-18-2848</u>			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Married</u>			
6. (b) Name of husband or wife <u>Silas D. Wolfensberger</u>				6. (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>July 9, 1911</u>				8. AGE: Years <u>36</u> Months <u>4</u> Days <u>21</u> If less than one dayhrs.min.			
9. Birthplace <u>Hagerstown- Wash. Co., Md.</u> (Town, county, and state)				10. Usual occupation <u>Restaurant Employee</u>			
11. Industry or business				12. Name <u>Lewis B. Munday</u>			
13. Birthplace <u>Washington County, Md.</u>				14. Maiden name <u>Josephine Loudenslager</u>			
15. Birthplace <u>Washington County, Md.</u>				16. Informant <u>Silas D. Wolfensberger</u> Address <u>16 Berner Ave- Hagerstown, Md.</u>			
17. Burial <u>Burial</u> Date thereof..... <u>Dec. 3, 1947</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory..... <u>Rose Hill Cemetery</u> Location..... <u>Hagerstown, Md.</u> <u>Fred W. Kraiss</u>				18. Funeral director Address <u>Hagerstown, Maryland</u>			
19. (Date rec'd by registrar) <u>Dec. 3, 1947</u> Registrar <u>Joseph H. Powers</u>				20. DATE OF DEATH <u>November 30, 1947</u> at P M 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Nov 1-47</u> to <u>Nov 30-47</u> and that I last saw him alive on <u>Nov 30-47</u> Immediate cause of death..... <u>Cocaine uterus</u> Due to..... Due to..... Other conditions..... (Include pregnancy within 3 months of death) Major findings of operations..... Date of op..... Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....				23. SIGNATURE <u>J. D. Smith</u> M. D. or other Address..... <u>Hagerstown, Md.</u> Date signed..... <u>11/30/47</u>			

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Middleburg Pike
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Middleburg Pike, R.F.D. 5
 (If rural, give LOCATION)
 2. (a) If veteran, name war Spanish American War

3. (a) FULL NAME

Bruce G. Wolford

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Susie S. Wolford
 7. Birth date of deceased (mo., day, yr.) November 16, 1874
 8. (c) If alive, give age 63 years
 8. AGE: Years 72 Months 11 Days 9 If less than one day _____ hrs. _____ min.

9. Birthplace Washington County, Maryland
 (Town, county, and state)

10. Usual occupation Retired Laborer

11. Industry or business

12. Name William Wolford
 13. Birthplace Fairview, Md.
 14. Maiden name Cunningham
 15. Birthplace Clearspring, Md.

16. Informant Mrs. Bruce G. Wolford

Address Hagerstown, Maryland

17. Burial Date thereof 11-10-47
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. Nov. 8, 47 Blossie Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7/47 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/7/47 to 11/7/47 and that I last saw him alive on 11/7/47

Immediate cause of death Chronic Sub-Carditis

Arterio-sclerosis

Due to ?

Due to ?

Other conditions ✓

(Include pregnancy within 3 months of death)

Major findings of operations ✓

Date of op. _____

Autopsy results 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

Signature V. H. Miller

23. SIGNATURE _____ M. D. or other _____

Address Hagerstown Md Date signed 11/7-47

CERTIFICATE OF DEATH

1. USUAL RES. (For males)

City or town

State

1. PLACE OF DEATH

County

City or town

How long in same place as stated

Residence, institution, or other address where death occurred

How long in hospital or institution

2. (a) FULL NAME

3. Sex (a) M (b) F (c) Other

4. (a) Name of husband or wife

5. (a) Is alive

6. (a) Date of birth

7. (a) Date of death

8. (a) Date of death

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9. Birthplace

10. Usual residence

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Education

Acquired

17. (a) Occupation or business

18. Cause of death

19. (a) Date of death

20. (a) Date of death

21. (a) Date of death

22. (a) Date of death

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE COUNTY HEALTH OFFICER, IN THE COUNTY WHERE THE DEATH OCCURRED.

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE COUNTY HEALTH OFFICER, IN THE COUNTY WHERE THE DEATH OCCURRED.

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE COUNTY HEALTH OFFICER, IN THE COUNTY WHERE THE DEATH OCCURRED.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Include exact age of deceased. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10444

93d

Reg. Dist. No.

302

I. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 50 years
 Hospital, institution, or street address where death occurred:
Potomac Hills
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Potomac Hills
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Harry L. Yingling

3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Widower
 6. (b) Name of husband or wife..... Goldie Yingling
 7. Birth date of deceased (mo., day, yr.)..... July 3, 1875
 6. (c) If alive, give age..... years
 8. AGE: Years..... 72 Months..... 4 Days..... 2 If less than one day..... hrs. min.

9. Birthplace..... Westminster, Maryland
 (Town, county, and state)
 10. Usual occupation..... Yingling Auto Sales & Service
 11. Industry or business.....

12. Name..... Ezra Yingling
 13. Birthplace..... Westminster, Maryland
 14. Maiden name..... Anna Marshall
 15. Birthplace..... Westminster, Maryland

16. Informant..... Maxwell Yingling
 Address..... Hagerstown, Maryland

17. Burial..... Rest Haven Cemetery Date thereof..... 11-7-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory.....
 Location..... Hagerstown, Maryland

18. Funeral director..... C. M. Suter & Sons
 Address..... Hagerstown, Maryland

19. Nov. 6, 1947 Registrar.....
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov. 5 19..... 47, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
9-18- 19..... 47, to..... 11-5- 19..... 47
 and that I last saw him alive on..... 11-4-47 19.....

Immediate cause of death..... Myocardial Infarction
 DURATION..... 6 hrs

Due to..... Coronary Arteriosclerosis
Heart Disease & Anginal
Syndrome
 Due to.....
 DURATION..... 4-5 yrs

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....

23. SIGNATURE..... Salmon W. Wells, Jr.
 M. D. or other.....
 Address..... 998 Potomac Ave. Date signed..... 11-5-47

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2. JALAL RIZOV
(1990-1991)

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